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QUALITY ASSURANCE UNDER PROSPECTIVE REIMBURSEMENT PROGRAMS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

FIRST SESSION

WASHINGTON, D.C.

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QUALITY ASSURANCE UNDER PROSPECTIVE REIMBURSEMENT PROGRAMS

FRIDAY, FEBRUARY 4, 1983

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The committee met, pursuant to notice, at 10:02 a.m., in room SD–538, Hon. John Heinz, chairman, presiding.

Present: Senators Heinz, Wilson, Melcher, and Bradley.

Also present: John C. Rother, staff director and chief counsel; Becky Beauregard, deputy staff director; Diane Lifsey, minority staff director; Bill Halamandaris, director of oversight; David L. Holton, chief investigator; Robin L. Kropf, chief clerk; and Angela Thimis, staff assistant.

OPENING STATEMENT BY SENATOR JOHN HEINZ, CHAIRMAN

Chairman HEINZ. Today, the Special Committee on Aging will examine quality of care protections as they relate to our Federal health insurance programs, especially medicare. But before I proceed any further I want to welcome a new member to the committee, Senator Pete Wilson of California. Pete, we are delighted to have you on this committee. Your State is the largest in the United States, you have a tremendous number of constituents who are affected by the work of the committee, we are proud to have you indeed.

Senator WILSON. Thank you very much, Mr. Chairman. I eagerly look forward to participating in the important work of the committee.

Chairman HEINZ. Earlier this week the Congress began its formal review of the administration's proposal to implement a national prospective payment system for hospital reimbursement under medicare. Our hearing today will look at the role of mechanisms which assure that patients receive a certain minimum level or adequate quality of care, and we will review this issue in the context of the proposal to reform our method of health care reimbursement.

Over the past 15 years, this committee has uncovered extensive and dramatic examples of the problems inherent in our present cost-based retrospective payment system of health insurance. We have documented shocking examples of fraud, waste, and abuse, which I estimated last fall to amount to the stunning total of $10 billion annually in both medicare and medicaid. But more important than these unwarranted costs to the program is the fact that

these abuses are invariably linked to patient mistreatment and mismanagement. It is a measure of the failure of our present reimbursement system that these fraud, waste, and quality of care problems ha e proved resistant to all of our determined efforts to eliminate them. A more basic reform is clearly necessary.

Recognizing this fact, this committee has long called for the development of a prospective payment system associated with more cost-conscious financial incentives on the part of providers. I applaud the administration's action in proposing such a reform for hospitals, based on the diagnostic-related group system as it has been tried in New Jersey. While we look forward to moving the legislation establishing a prospective system for medicare, we cannot ignore its potential implications for quality of care. A prospective payment system is in essence a contract. The Government agrees to pay a specific amount for a specified service. At that point, it becomes the Government's responsibility to insure performance, that is, were the essential services delivered? The purpose of our hearing today is to assess our ability to meet this responsibility.

Regrettably, we have before us today a flagrant case where this responsibility was not met in a skilled nursing facility operating under a medicaid prospective reimbursement system in Texas. Fifty-six people are alleged to have died needlessly in the Autumn Hills Convalescent Center in Galveston, Tex. Thirty-eight indictments charging murder have been issued by a county grand jury against the corporation operating the facility and eight of its current or former employees.

In a sense, this grand jury action represents a failure of more traditional remedies. Problems in this facility have repeatedly been noted by health inspectors, surveyors, and the public. Sanctions were ordered without result. An attempt to decertify the facility proved unsuccessful. Finally, faced with the impotence of the existing quality assurance mechanisms, plaintiffs took their complaint to the grand jury.

In all, three grand juries have examined this matter over the last 4 years. Two have brought indictments calling for prosecution of the corporation and its principals under homicide statutes. It now appears that a fourth grand jury will be called.

Whatever guilt or innocence is determined in the judicial process, the fact is, that the delay in reaching any conclusion is totally inexcusable. This delay reflects an indifference to the fate of older Americans simply because they are growing old. If half a dozen of my coal miners in the State of Pennsylvania were to die in a mine accident, it would be cause for an immediate investigation. Responsible State and Federal agencies would spring into action and not rest until the reason for the accident was identified and some corrective action were ordered and taken. And if a gross safety violation were involved, it would be a national scandal; it would be covered for weeks and months on the nightly news. Yet somehow when 56 people die needlessly in a nursing home it is largely ignored. I fear, frankly, that it is ignored, somehow, for no better reason than the horrible presumption that human life somehow has less value as it nears its end; that people who are old are going to die soon anyway, so who cares.

Fairness to those who died, their families, and the corporation that stands accused demands a full judicial review of the allegations raised by this case and a decision on its merits. This committee will do everything in its power to assure that outcome.

I want to emphasize that as we hear testimony on Autumn Hills, these specific quality care problems are not an indictment of the prospective reimbursement methods per se. These problems are not unique. These same kind of problems have repeatedly occurred under our current restrospective payment methods. What the Autumn Hills' case illustrates is that the prospective reimbursement alone will not take care of our quality care problems. As we implement a new system, we must learn from, rather than repeat, our past mistakes.

We are also going to hear this morning from those with hands-on experience in prospective reimbursement systems at the State level. Currently, over three-fifths of all States reimburse nursing homes for medicaid patients prospectively. Within the State of New Jersey, the quality assurance standards of two professional review organizations merit our review as potential Federal models. We will also review the quality assessment mechanisms developed by the prosecutors, the State medicaid fraud investigators, and Rice University experts in connection with the Texas case.

I look forward to hearing the testimony today, some of which I regret will be unsavory, and to working toward the development of both cost-effective and quality-assured health care for our Nation's older population.

Before we hear from Senator Wilson and our witnesses, I am going to insert, without objection, the statements of Senators Charles Grassley and Larry Pressler. Unfortunately, due to prior commitments, they will not be able to participate in today's hearing.

[The statements of Senators Grassley and Pressler follow:]

STATEMENT OF SENATOR CHARLES E. GRASSLEY

Thank you Mr. Chairman for calling this hearing that will take a look at the feasibility of prospective payment to hospitals, skilled nursing facilities, and other providers.

The real key to this hearing is not whether formulas, computers, and medical procedural expenses can all be combined to accurately predict the cost of care to diagnosis-related groups. The marvels of this computer era will no doubt accomplish this sort of high-tech formulization. What we here this morning want to learn is will the quality suffer during and after a transition from retrospective to prospective care?

There is no doubt in my mind that all here this morning care very much that quality not suffer while TEFRA directives are carried out, but we need to know how quality assurance activities are made an integral part of prospective payment systems.

What allowances are made for small rural hospitals and SNF's who are the sole community providers for wide areas of rural America? Will these areas be further abandoned by medical professionals?

I know that Ms. Davis and her staff have worked hard on this plan. The staff of this committee, and Senators' staffs, have been briefed well and at length by HCFA professionals, and I want to thank you, Ms. Davis and your staff, for helping so thoroughly. Hopefully, this morning will see more questions answered and facts shared on a plan that is bold in concept and fiscally responsible. Both qualities that are needed to stem the skyrocketing medical costs facing citizens, health care providers, and their Government alike.

STATEMENT OF SENATOR LARRY PRESSLER

Mr. Chairman, I would like to commend you for calling this hearing. One of this committee's most important functions is its responsibility to act as an advocate for the Nation's 26 million older Americans. The recent proposal with regard to prospective reimbursement under medicare should be analyzed carefully before it becomes effective. I understand and support the need to control the growth of medicare expenditures, but I think we would be in error if we did not thoroughly examine the means by which we propose to do so. Many good intentions have been translated into regulations which have had other, unintended, effects. As a result, I believe that this morning's hearing is very timely and important.

Earlier this week I met with several hospital administrators from my home State of South Dakota. There are 58 hospitals in my State, and many of them are small, community facilities. They are concerned, justifiably, that setting prospective limits on reimbursement will force them to either cut back in services or pass on any additional costs to other patients. The proposed regulations note that the Secretary will make special adjustments or exceptions for sole community providers. I am concerned about the details of any such provisions, and would hope that they can be made public before these regulations go into effect.

The issue of quality of care will be addressed by several witnesses this morning. The committee has identified certain problems that have arisen in relation to existing prospective reimbursement systems, and we will be hearing more about those. While I realize that the potential for fraud exists in any system, it seems that there should be steps taken to minimize these opportunities. I remain sure that the majority of our hospitals and nursing homes conscientiously provide a high level of care, but we must eliminate fraud and abuse wherever we find it, so that our taxpayers' dollars are spent for the care of those who need and deserve it.

Again, Mr. Chairman, I thank you for bringing together this morning's hearing, and I look forward to the testimony of our witnesses.

Chairman HEINZ. Senator Wilson, do you have an opening statement that you would like to make?

Senator WILSON. No, Mr. Chairman, I would only echo the sentiments that you have just voiced, and I think that you are quite right in drawing the distinction that you have between the prospective method of payment, which I think has a great deal to recommend it, not just the abuse, but the incredible story that appears to be unfolding in the instance of this provider.

But I would now eagerly await the testimony.

Chairman HEINZ. Very well. Our first witness is David Marks, former assistant district attorney of Galveston, Tex.

Mr. Marks.

STATEMENT OF DAVID MARKS, FORMER ASSISTANT DISTRICT ATTORNEY, GALVESTON, TEX.

Mr. MARKS. Good morning, Mr. Chairman. On October 22, 1979, a young Galveston prosecutor, while moving some belongings into a new office, discovered a small dusty file which had been placed behind some books on a shelf. Contained within this file were documents reporting extensive practices of fraud and patient neglect by a nursing home located in Texas City, Tex.

This file, which upon discovery was less than 1 inch thick, subsequently grew to occupy six full rooms of evidence, and became known as the *State of Texas* v. *Autumn Hills.*

My name is David Marks, and I am the young prosecutor who discovered this file and who conducted the inquiry into the allegations contained in it.

I come before you now, 3 years and 4 months later, not for the purpose of trying this case, not for the purpose of divulging confidential grand jury information, which I cannot do, nor to call at-

tention to one more physical atrocity against the elderly in America's nursing homes only to be added to an unending list of horror stories which have been elicited before this very committee over the past decade. But rather I am here today, at your request, to call attention to another kind of atrocity, an atrocity of perhaps an even greater magnitude which involves the failure of a system, of an enforcement system to protect the sick, helpless, and dependent elderly in nursing homes.

Permit me to begin my remarks in this vein by telling you a little bit about the origin of this case.

When I found the Autumn Hills file in October 1979, my initial reaction was that of curiosity twinged somewhat with a smattering of annoyance, annoyance at the fact that this was a file which had not even been shown the dignity of being placed in the file cabinet with the rest of the cases in the misdemeanor division. However, as I began to review and read the documents contained in the file, I became perplexed. The reports in the file indicated that the facility had defrauded the State of Texas some $67,000. Other reports suggested that essential services had not been provided patients and, as a result, death had been caused.

The question I had, the perplexing question I had, was what was this matter doing in the misdemeanor division. I spent the next 2 days analyzing the material contained in the file, wallpapered my office with butcher paper——

Chairman HEINZ. Mr. Marks, could you withhold for a minute. Because you are talking about a case here, I think I ought to swear you in.

Mr. MARKS. Certainly.

Chairman HEINZ. So please stand and raise your right hand.

Do you swear the testimony you are about to give will be the truth, the whole truth, so help you God?

Mr. MARKS. I do swear.

Chairman HEINZ. Please proceed.

Mr. MARKS. Thank you. I was saying that in reviewing the file I approached it by reviewing the information, outlining it both chronologically and by subject, and then began to place the relationships between the subjects on butcher paper, which I had wallpapered my walls with.

Later, every record relating to the operation of the nursing home over a 2-year period of time were subpenaed.

As the focus of the investigation began to shift from initially the fraud aspect to the death aspect, because originally my first reaction was, this is a fraud case with a peripheral issue of deaths related to the fraud. However, that changed within the first 2 weeks to a death case with a peripheral issue of the fraud. As that began to change, and as the information began to develop, over 200 witnesses were interviewed and subsequently presented, or their testimony and summaries thereof presented, before a Galveston County grand jury beginning October 16, 1980.

Subsequently the grand jury returned indictments against the Autumn Hills Corp., and certain high managerial agents. These ultimately were redrafted with the theories and the allegations being essentially as follows:

No. 1, that high managerial agents and the corporation knowingly omitted essential nursing care, basic Red Cross care, thereby causing the death of patients.

No. 2, was a felony murder theory that in the course of committing a felony; that is to say, in the course of tampering with a nursing home chart and record, by representing that services had been provided, when in fact they had not been provided, in the course of committing this felony, the corporation and high managerial agents committed acts clearly dangerous to human life which caused death.

The third theory was also a felony murder theory, and was essentially that in the course of committing medicaid fraud, to wit, by representing that services had been provided when they hadn't been provided and thereby accepting money for this, and in the course of committing this felony, high managerial agents in the corporation recklessly acted, thereby causing the death.

Having briefly described the origin and also the theory utilized in this case, let me next turn to the facts of this case and the methodology utilized to uncover them.

In 1979, a multidisciplinary team of experts consisting of forensic pathologists, geriatricians, gerontologists, epidemiologists, geriatric pharmacologists, geriatric nurses, auditors, system research engineers, and medicaid fraud investigators, as well as a medical records administrator, statistician, dietician, and numerous other medical specialists began to extensively review literally every record compiled by the nursing home in the course of its operation. These experts were selected on the basis of their high standing and achievements within their respective fields.

The documents reviewed included all patient medical records for a 2-year period of time, patient medication reviews, census reports, consultant reports, nursing supply invoices, food supply invoices, payroll, cost reports, all financial records, and facility policies and procedures.

Independent documents secured from sources outside the nursing home and analyzed included prior and subsequent hospital records of the nursing home residents, pharmacy prescriptions, drug destruction records, medicaid nursing evaluations, financial audits, and all Texas Department of Health inspections, complaints, and memorandums relating to the nursing home for the 2-year period of time.

During the course of this 3-year investigation, each of the above groups of documents was reviewed numerous times by this multidisciplinary team. The goal of these experts was to dissect the records and to identify all key components, all key variables in the provision of nursing home care. The resulting data sets were in turn coded and then loaded onto computers located in Washington, D.C., Los Angeles, Houston, and Austin, Tex., for the purposes of systematic analysis.

Such analysis of the nursing home configuration; that is to say, the analysis of all ingredients which go in to make up nursing home care, revealed that there were two primary ingredients necessary in the provision of nursing care. Those two primary ingredients were adequate staffing and adequate supplies. Essentially, what I am speaking of and worth talking about is adequate re-

sources. These resources or these two essential ingredients were necessary in order to meet the six basic needs of patients—the need for nutrition; the elimination needs; the sanitary needs of the patient; the movement needs of the patient; the medical and treatment needs of the patient.

In approaching the cases at hand, it was my goal to retrospectively review the quality of services provided and to attempt to measure quantitatively, if possible, what portion of these services were provided, what portion of the nutritional and elimination needs, et cetera, were provided, and what were not provided.

An assessment of the facilities' capacity to meet these needs based on this analysis is displayed on the charts before you now, or will be displayed. We will be using easels A and B, easel A being the easel closest to myself; B being the easel closest to you, Mr. Chairman.

Chairman HEINZ. Mr. Marks, before you proceed, let me just announce the presence of Senator Bradley of New Jersey.

Bill, we are delighted to have you here. As you may know, some of your constituents will testify in a few minutes.

Senator BRADLEY. Thank you.

Chairman HEINZ. Mr. Marks, please proceed.

Mr. MARKS. With respect to the essential ingredients of licensed staff available, analysis revealed that in a period of time from March 1976 to May 1978, 65 percent of the days, Autumn Hills was not minimumly staffed, did not have the adequate or the minimum licensed number of staff on hand, and I emphasize the word "minimum." Sixty-five percent of the days, or in this timeframe, a total of 512 days; the chart before you broken down by month and by reading from left to right you can see the number of days per month where there was violation of minimum licensed staffing requirements [see chart 4].

[All charts referenced appear at end of testimony, pages 25 to 30.]

Mr. MARKS. With respect to the essential ingredient of supplies, one of the most essential, obviously, is nutrition; and we have used as an example of the supply shortage in this particular facility an analysis of a feeding formula which was used for patients. This formula was the only formula which these patients could or were provided at the particular facility. It was their sole means of caloric intake, their sole means of a meal, a liquid meal. A zero point was identified wherein there was absolutely no feeding formula within the facility. From that point, a supply-demand analysis was conducted whereby the amount of supplies purchased, the amount of feeding formula purchased, was compared to the amount of feeding formula necessary, as determined by adding up all the treatments by the physician and all the units of feeding formula needed within the entire patient population by day.

A comparison revealed—and the comparison is broken down by receipt date of the particular supply—comparison revealed that during the period of time from May 6 through May 28, Autumn Hills needed 999 units of feeding formula. Purchased were 480 units. The next receipt of feeding formula came on May 27. The timeframe next is, that receipt date, the 27th to June 3, the next receipt date; and during this timeframe, 360 units of the feeding

formula were purchased. Needed during this small time, 422. As you can see, reading from left to right, the discrepancies are quite large; 360 needed—or 360 rather, bought or purchased; 622 units of feeding formula necessary; 360 compared to 463 needed by the patient population [see chart 1].

On June 24, 1980, 360 again was purchased; what was needed during the timeframe before the next shipment came in, 853 units of the feeding formula. Finally, 360 again purchased; again, what was needed during this timeframe, 652 units.

If I could direct your attention now to the next chart, we will explore what the response of this facility was to these gross inadequacies in these two very key and important ingredients [see chart 3].

Through an extensive investigation and review, it was determined that during the period of time from March 1976, to May 1978, Autumn Hills falsified 45 percent of the licensed staffing levels during this timeframe. The days falsified are indicated, again left to right, an example being in March 1976, 16 days, falsifications were found during that particular month; 23 days and so on, until April of 1978 were 15 days.

Cumulatively, it was determined that 354 days during this particular timeframe were falsified. In other words, 45 percent of the licensed staffing levels were falsified, so as to indicate that the requirements for minimum licensed staff levels were indeed satisfied.

What was the response with respect to this crucial ingredient of supplies? Let's turn back to our feeding formula example.

Autumn Hills response to falsification of 43 percent of the feeding formula. In other words, it was represented in the charts that 100 percent of the particular feeding formula, the sole caloric means of intake for these patients, that 100 percent was provided. Forty-three percent of those representations during this timeframe were false, or cumulatively of 1,731 units of feeding formula, crucial nutritional substance for these patients during this particular timeframe.

Directing your attention again to easel B, the one closest to you, Mr. Chairman. I will wait until she catches up with me. Let me elaborate a bit on what the effect of this feeding formula shortage was [see chart 2].

The effect of the supply-demand differential during this particular period of time was one of two things. There were two alternatives. Either 43 percent of the patient population depended upon feeding formula, the liquid nutritional substance, did not receive such substance. The first portion of the patients, as indicated by the charts, being fed, the last 43 percent not. Or, the entire patient population who was dependent upon this feeding formula as their sole means of caloric intake, received only 57 percent of what was ordered by their physician.

What was the Texas Department of Health response? We will come back to it in a second, but let me briefly touch upon it now. Analysis of the Texas Department of Health action, with respect to the facts which I have just communicated, revealed that from a period of time of January 1978 until August 1979, the facility was on some form, or placed on some form of sanction, 61 percent of those days, 61 percent for either life-threatening, dangerous level of patient care, or was placed on sanction for inadequate level of pa-

tient care falling below the minimum standard of care [see chart 5]. The larger columns or bar graphs indicate the sanction days for dangerous level and life-threatening care; whereas, the smaller bar graphs suggest and indicate the sanction days for below minimum standard care. Again, 61 percent of the days during this period of time this facility was on sanction for either dangerous, life-threatening care or below minimum standard care.

What was the financial outcome? In other words, what do the analysis of the medicaid revenue of Autumn Hills and their profits reveal?

Directing your attention to easel A first, this graphic presents a medicaid revenue schedule for the Autumn Hills facility, which had a capacity of 120 beds [see chart 6]. As you can see, the facility revenue is broken down, and I will briefly summarize, because I know my time is short.

In 1976, the total revenue for Autumn Hills was $799,000; increasing to $841,000 in 1977; and finally, $830,000 in 1978. Eighty-six percent of this total revenue was medicaid money. As you can see by the chart displayed on easel B, a hypothetical facility has been mentioned and referred to so as to draw a comparison for you [see chart 7].

Assuming that we had a hypothetical facility by the name of Spring Valley who provided 100 percent of all requirements, who provided 100 percent of the services of the patient, a like-patient population as that of Autumn Hills. They would have received the exact same amount of money as Autumn Hills, even though in light of the 61 percent of the days during this timeframe I've mentioned that Autumn Hills was on sanctions for inadequate life-threatening care.

In summary, the financial penalty was zero for Autumn Hills, zero during this period of time. If I may very hurriedly direct your attention finally to what this means. What is being—in a relationship between services provided and medicaid revenue, is there a positive correlation between medicaid reimbursement and services provided?

The chart on easel A depicts using the hypothetical Spring Valley who provided 100 percent, it depicts the dilemma we are presently in.

Spring Valley, on your left, providing 100 percent of the services, representing a full beaker, receives the exact same amount of money as Autumn Hills, represented on your right, presenting very inadequate services [see chart 8]. There is a cost incentive presently existing, I submit, to provide inadequate care under the present reimbursement system, at least in the State of Texas.

What was the response of the Texas Health Department through all of this, the department that was supposed to be the safety mechanism, guaranteeing and protecting these rights and safeguarding the lives of these individuals? Our review of the record, related to this case, indicated that the Texas Department of Health was well aware of the many problems illustrated in these charts. As I have discussed, 61 percent of the days sanction imposed. Although inspectors were pleading for decertification of the facility as early as August 1978, reporting large numbers of deaths, inhumane treatment and abuse, and a gross neglect on the part of the facility,

no action was taken by the Texas Department of Health except to temporarily withhold medicaid funds. The facility was in no way prevented from accepting patients or conducting business, nor did it receive, as I have stated, a single financial penalty.

The field staff had identified the problems; however, when their reports were transmitted through the heirarchy of the health department, they were misvalued. The impotence of the department was further exhibited by its acceding to the wishes of Autumn Hills in transferring the inspector who had been most vocal in criticizing the quality of care provided at the facility. And by succumbing, succumbing to the influence of State legislators, who, at the request of Autumn Hills, sought to circumvent the system by requesting reinspections.

This course of conduct effectively pulled the last tooth from a nearly already toothless inspection process. As a result of the impotence of the department of health and the absolute failure of this safety mechanism, this matter subsequently wound up in the criminal justice system. Unfortunately, Mr. Chairman, I am unable to say that the response of the criminal justice system has been much different.

This case, like the nursing home residents it reflects, was intended from the beginning to die of neglect. Throughout the course of the investigation and the pendency of the case of the *State of Texas* v. *Autumn Hills,* which lasted from October 22, 1979, through December 1982, we were plagued by critical logistical problems; a statement of the degree and nature of these problems is contained in the affidavits, which will be appended to my testimony, and for brevity, I will submit them to the record.

Chairman HEINZ. Without objection, of course.[1]

Mr. MARKS. The response finally of the criminal justice system is further demonstrated by the events which transpired on December 27, 1982. On that day, the corporation was allowed to plead no contest to the reduced charge of reckless homicide and granted a form of probation under Texas law. Approximately 265 counts of murder were dismissed. More importantly, not one single individual who was responsible and engaged in the conduct which I have suggested and presented before you, not one single individual received a sanction, a criminal sanction. They left the courtroom with nothing but big smiles on their faces on December 27.

I think the emptiness of the plea bargaining arrangement is exemplified by the deferred adjudication of the probationary terms. The corporation was granted a form of probation wherein if it was a "good boy" for the next 10 years, then all charges that they had pled to, would be dismissed, and it would be as if 56 people had not died; as if the things which I have presented to you today had never occurred.

However, the irony of this arrangement was that 4 days later, the facility changed hands and a new corporation assumed control. The effective probation lasted 4 days.

In light of the gravity of the facts of this case, I deem this plea to be an absolute insult to our system of justice. Had these victims

[1] Retained in committee files.

been infants as opposed to elderly residents, the thought of a plea would have never entered a prosecutor's mind.

In conclusion, Mr. Chairman, after extensively examining a facility which repeatedly refused to respond to the extensive and serious warnings about life-threatening care; after reviewing the failure of the Texas Department of Health and their impotence in responding to these crucial and critical conditions; and, finally, after personally experiencing the near failure of the criminal justice system to react to the situation at hand, I cannot help but conclude that justice stops at the nursing home door.

No department, office, or industry seems to be willing to accept the role as guardian for American nursing home residents.

Mr. Chairman, that concludes my prepared remarks.

Chairman HEINZ. Mr. Marks, thank you very much.

You were describing at the end the circumstances under which the plea bargain was entered into between the State of Texas and Autumn Hills Nursing Home. On January 24, last month, I announced that these hearings would be held, that we would call you and others as witnesses. Could you tell us what has happened to the plea bargain that was entered into on December 27, since January 24?

Mr. MARKS. Yes, sir.

The plea bargain which was consummated on December 27 was subsequently annulled—I don't have the exact date, but a short time ago and, as a result, the cases of the *State of Texas* v. *Autumn Hills* have been apparently resurrected, setting the stage for perhaps a public inquiry and finally public adjudication as to the facts which transpired with respect to this decision.

Chairman HEINZ. I think an examination of the actual dates will show that 2 days after this committee announced that we would hold this hearing, the plea was vacated, on January 26.

Mr. Marks, what has happened to you? You were a—you have been an aggressive prosecuting attorney, assistant D.A. Are you still the assistant district attorney? Will you prosecute this case?

Mr. MARKS. No, sir. On December 16, it came to my attention, or immediately prior thereto, that a bargain had been struck with respect to this case, a plea bargaining arrangement. As lead prosecutor, I had never been informed of any such negotiations. I think those aspects are beyond the scope of this hearing, but suffice it to say, I felt that the arrangement had the appearance of impropriety, so on December 16, I attempted to restrain the district attorney of Galveston County, Tex., from taking any part in the proceedings which were planned to take place on December 17.

The court of appeals subsequently heard the restraining or the—we sought a restraining order. The court of appeals subsequently restrained temporarily all parties involved in the agreement for 10 days, to December 27. Since December 16 when I was terminated, I have worked literally night and day inquiring into the plea bargaining agreement itself, which I deemed not to be supported by facts and law of the case, as well as preparing for this particular hearing.

Chairman HEINZ. In sum, you were fired for your prosecution of this case?

Mr. MARKS. That's correct.

Chairman HEINZ. Mr. Marks, for the record, you have been discussing the activities of Autumn Hills Convalescent Center, Inc. As I understand it specifically, most of the testimony that you have given us relates to just 1 of 17 facilities that the corporation controls; is that correct?

Mr. MARKS. That's correct.

Chairman HEINZ. Now, I also understand that several of the other facilities have received excellent ratings from the State of Texas; is that correct?

Mr. MARKS. It is my understanding that under the system existing in the State of Texas that certain or many perhaps Autumn Hills' facilities have received what is known as a superior grading in the State of Texas.

Chairman HEINZ. Are those ratings therefore indicative of those being substantially different than this facility?

Mr. MARKS. I believe that the superior grading system in the State of Texas is an absolute farce.

Chairman HEINZ. Why?

Mr. MARKS. No. 1, the grading takes place annually. It takes place at the annual Federal survey, known as the big book survey. The facility is able to gage not only from a year from the date of their last particular inspection and also through the grapevine, they are able to know specifically when the inspection or the grading is to take place. That provides them an opportunity to put on their Sunday best and as a result, first of all, this Sunday best does not reflect the level of care being provided during the other 365 days and so they——

Chairman HEINZ. They receive advance notification to get ready? Are there any other problems?

Mr. MARKS. I need to qualify. They don't receive advance notification but they know.

Chairman HEINZ. They get it somehow?

Mr. MARKS. They get it. Yes, sir.

Second, and most importantly, I believe, that an inspector who is rating that facility is not allowed to consider any of the historical data concerning the facility. Two weeks before, they could have neglected a patient to death and yet the inspectors—blinders are placed on the inspectors and they are only allowed to make their grade based on the 3 days that they are in the facility. In fact, there are examples where facilities in the State of Texas have been scheduled for decertification which is the strongest sanction which can be imposed in the State of Texas, decertification 3 months before a superior grading is to take place, and yet, then they have subsequently received a superior grade, which indicates and represents to the public that this particular facility is providing superior nursing care. That is not correct.

Chairman HEINZ. Let me ask you this. One of the most frequent responses we get when we examine nursing home problems is that the payment rates are inadequate, that they encourage abuse because they are inadequate.

What do you know of the profitability of nursing homes based on your experience with Autumn Hills? Would you say that there is a profitability, that is the reason that the services may have been withheld rather than delivered?

Mr. MARKS. Mr. Chairman, one of the prime concerns I had was to determine whether or not the reimbursement system itself was in any way responsible for the inadequate care provided at Autumn Hills. And if I may direct your attention to easel B, there is a chart which presented the question: Is the reimbursement rate to blame? [See chart 9.]

What has been done is the 758 proprietary nursing homes in the State of Texas have been compared to the major industries in the United States, utilizing the Value Line Investment Survey as a basis for such a comparison. As you can see, the 1979 net profit margin places the 758 proprietary nursing homes well within—approximately within the middle of the net profit margin of major industries.

More importantly, however, is return on capital, the return on equity. As you can see, the nursing home industry in the State of Texas is more profitable, or the return on equity is greater, than the oil industry, than retail stores, natural gas, fast food, Texas banking, and medical services. It leads.

Now, specifically the Autumn Hills Corp.—and if you will take a look at the average return in equity for the proprietary nursing homes in the State, it is 33.8 percent; in 1978, the Autumn Hills' return on equity prior to taxes was close to 111 percent.

Chairman HEINZ. Is the 33.8-percent return on equity before or after taxes?

Mr. MARKS. I believe that's before taxes.

The 95 percent or—excuse me—in 1979, Autumn Hills' return on equity, which compares to the 1979 return on equity here, was 95 percent.

Chairman HEINZ. Three times.

Mr. MARKS. Three times that of the average return in the industry.

Chairman HEINZ. It would be a little hard to say that they were having difficulty making a profit, then that was the reason services might have been withheld?

On the other hand it suggests that there may have been other motivations beyond necessary, proper and necessary profit, such as greed?

Mr. MARKS. Yes, sir.

Mr. Chairman, if I might add one thing, you were inquiring with respect to the superior rating system, and I think the major point to be made here, if I may go back to that point very briefly, is that the grading system is not an index of nursing care. Bonus points, you get bonus points from all areas. There are six or seven areas, one of those being nursing care. And what is important to note here, that the crucial aspects of the nursing process are not brought out, are not utilized in the grading tool which is presently being utilized in the State of Texas.

For example, while the inspectors are in the facility, while they are there, they can fail to observe a patient during the entire 3-day period the inspection takes place, fail to observe, and more importantly, fail to intervene, thus resulting in a critical condition. And there is no place in the grading system to give either the nursing home a demerit and more importantly, a nursing home can be given the bare minimum care, even have demerit points in the

nursing area and still receive a superior rating under the Texas rating system.

Chairman HEINZ. Mr. Marks, the bottom line on all this is that as we move toward a prospective reimbursement system for health care in this country, we want to learn how to avoid the kind of experiences just described.

What should we do about it? I think you made reference to an enforcement tool that would reverse what you have described as the toothless inspection process.

Can you enlighten us a bit on how you would suggest that the authorities, whether they be State or Federal, attack this kind of a problem, monitor it so that we don't get into a situation where 5 years from now we are having another hearing with the same kind of tragic implications?

Mr. MARKS. Yes, sir, I will be happy to discuss with you the system which was developed, and I believe you have before you a cutdown version of this system. And I will go through it and explain briefly how it works and relate it back to some of the graphics which have been displayed here today.

Essentially, this system presents for examination a large and comprehensive menu of variables operating within a nursing home configuration. Analysis of variable relationships is facilitated by organization of all this data, all the ingredients of nursing home care, into major categories, subcategories and specific categories. And if I may direct your attention specifically to chart 10.

As you can see listed here are the major analytical categories. These are the major categories necessary and which are the categories appearing in the provision of patient care. These are relevant.

First, we have patient inputs or patient assessment; second, what are the patient demands? What services does each patient need; third and fourth, what happened to the patients, which is patient outcome or, going down the matrix, what type of failures occur, what nursing intervention failures, medical intervention failures occur? Fifth, what was the Autumn Hills' input. In other words, what staff did they provide? What supplies did they provide, what training did they provide? Sixth, what was the Texas Department of Health's input? In other words, what was their analysis of the care being provided; and, finally, seventh, what was the financial array or the paralleling financial condition of the facility.

These are broken down on chart 11 into more specific categories and a location matrix is provided, which I will demonstrate its use momentarily; and, finally, looking to page 1A of your sheet, the detail matrixes. You have only, I believe, two pages of detailed matrix. There are numerous and many of these pages and we have included only two for purposes of illustration.

Let's go through and see how this system works. And if I may direct your attention to chart 1, and let's take a look at the graphic display appearing in the upper left-hand corner. As you can see, that is one which was utilized earlier today and compares facility resources versus the patient demand, or the patient needs.

Chairman HEINZ. Do you want to have your assistant put that same chart back up?

Mr. MARKS. That would have been, I believe, 1A, the first chart.

No, I believe it's 1B. No, it would be either one of the others. That's it. Thank you. All right.

Directing your attention both to easel B and the graphic display in your version.

As you can see, we went through and expounded upon the supply-demand differential. Now, how was that arrived at?

Let's first take a look at the major analytical category. What are we really talking about here. Directing your attention back to chart 10, the analytical, major analytical category, we see, looking down the matrix, the first thing we see is patient demand profile. OK. What that simply signifies is what are the demands of the patient. And since we're talking about supplies, what are the supply demands? Now, we are comparing the supply demands to the Autumn Hills' input configuration, and if you will look at the labels running vertically, we find that running vertically in the matrix. So we know we are comparing inputs of Autumn Hills to demand. Now, then, let's go to the location matrix, which is found on chart 11.

Looking under and looking for the major category which we spoke of, Autumn Hills' input configuration. Going down vertically, we find and see the major category, Autumn Hills' input configuration. Has everyone found that? It's located again on chart 11.

Chairman HEINZ. In sum, what I think you've done, Mr. Marks, is to array for each individual patient a tracking system, a system where you clearly identify what the patient's diagnosis or problem was, what the physician prescribed, what kind of nursing, what's happened to the patient, and so forth. And what you're suggesting is that if there was a followup system by the State, or by medicare, or by somebody we trusted, that this would in effect, avoid the kinds of problems that we have seen, not just of the kind that you've set forth and described today, but we've seen in other situations. That in sum is what you are saying.

Mr. MARKS. Yes, sir.

Chairman HEINZ. And you've given us a very concrete, very detailed matrix with which to work.

I want to commend you for having gone far and above the call of duty in this, not just in drawing to our attention the problems that you've been specifically associated with, but most specifically to making the kind of detailed suggestion to the committee that you have as to how we can, as we move toward a prospective reimbursement system, minimize these kinds of problems.

I suspect that there is no perfect solution that will avoid every single problem. We have got problems now under the retrospective, cost-pay system; I'm sure we'll have some, no matter how hard we try under any new system. But I just want to take this opportunity to commend you on your testimony and on your help to the committee. And I do want to call on Senator Wilson for any questions.

Senator Wilson.

Senator WILSON. Thank you, Mr. Chairman.

Mr. Marks, as the net result of your prosecution in the detailed investigation that you conducted into this, what specific recommendations do you have for improving the mechanisms which exist for the monitoring of the adequacy of health care, and specifically for

dealing early in a preemptive and preventive way, for the kind of situation that unfolded in this case.

Mr. MARKS. Well, I believe the problem existing today with the present evaluation system are that they focus upon inputs, and they focus upon things which have not been weighted, inputs which have not been weighted. We do not know, and responsible governmental agencies are unable to understand the relationship, whether these inputs are crucial or noncrucial to the provision of care. There is no weighting presently in the inspection process. There are no evaluative indices, so as to allow those responsible for fiscal oversight for the $24.2 billion being provided annually in nursing homes; there is no way or mechanism for them to monitor what type of services they are receiving in return for the money they are providing. And the system which was utilized to uncover the facts and to ferret out the evaluative indices possibly may be utilized not only in this particular situation, but across the United States.

I am not here suggesting that I am an expert in nursing home care. I have given 3½ years of my life to it. But I definitely feel that at the very minimum, this system merits some inquiry and further study to determine whether or not it can be used as an aid to help this committee, and other responsible governmental agencies, to determine that very thing, what services are we getting for the money we are providing.

Senator WILSON. Is it a fair statement from your experience in Texas, which I think—you say you're not an expert—but having given 3½ years, you have clearly developed some expertise.

Is it a fair statement based on your experience that even though the State, in this instance, the department of health, has an official role in certification and in imposing some sanctions, that what happened here was that it was almost accidentally, that really an egregious case came to light. And what you have recounted to us really is details of neglect in two different ways: First, on the part of the subject institution and second, on the part of both the State health system and also, according to your testimony, the criminal justice system in your county.

What I think we need to be concerned with, wholly apart from the specifics in this instance, is to determine whether or not the system for monitoring health care is adequate, and whether or not there is an early warning system that can prevent this kind of thing. I think we have really got two issues: Those occasioned by your uncovering these specific abuses, separate, and from the way I gather the subject of our inquiry this morning is prospective systems of payment; and I gather really that there is no particular relationship, that what you have found here could have occurred if we were looking at a system of reimbursement.

So I am asking two questions. It seems to me those issues are clear and distinct and second, with respect to abuses of the kind that you have spent these 3½ years on, is there, after your examination of the specifics in this instance, specific suggestions that you would have to see that this doesn't occur again in Galveston County, or any place else in Texas, or the Nation?

Mr. MARKS. Yes, sir. I believe that the issue here is that of enforcement and accountability; some teeth have got to be placed into

the enforcement system. This case should have never fallen into the criminal justice system. It should have been stopped long before that. If the agencies who were supposed to have been the safety mechanism to prevent this type of situation had been acting in accordance with the mandates of Congress to assure safe and adequate care to these individuals, we would have never reached this stage.

Again, I believe that the issue is not more strict laws, but something has got to be done with respect to the enforcement. My suggestions are that a study be implemented to determine what type of enforcement is existing today, whether this situation, in other words, is symptomatic of situations across the United States. And then some resolutions as a result of that study be determined and made for how to bone up what I believe to be a very weakened system.

Senator WILSON. Well that, obviously, is the other question that your testimony presents, and being new to the work of the committee, I am in no position to respond, except that a casual reading of the newspapers from time to time discloses abuse in senior citizen health care facilities is not uncommon, and I would have to say I think in defense of the industry, and the many practitioners who deliver quality care, that many are doubtless tarred with the brush of what I hope are only a few violators, but our focus properly this morning is on the violators.

One of the questions that occurs to me, Mr. Chairman, is how whatever deficiencies may have existed in this instance are peculiar to the State of Texas, or whether they relate to a pattern. I don't know whether the system of enforcement which Mr. Marks has found deficient here is pretty much the same from State to State, or whether or not in this particular case there is something that needs correction that is not universal.

Chairman HEINZ. I might suggest, Senator Wilson, that we will have some witnesses from the GAO, General Accounting Office, and from the Health Care Financing Administration who may be in the best possible position to answer those questions.

Senator WILSON. Fine. I will await their testimony.

Thank you, Mr. Marks.

Chairman HEINZ. Senator Bradley.

Senator BRADLEY. Thank you very much, Mr. Chairman, and Mr. Marks, for your testimony.

Before asking the witness any questions, Mr. Chairman, I have a statement that I would like to submit for the record.

Chairman HEINZ. Without objection, the statement of Senator Bradley will be inserted in the record at this point.

[The statement of Senator Bradley follows:]

STATEMENT OF SENATOR BILL BRADLEY

Mr. Chairman, colleagues, and guest. Everyone wants to insure that the sick and the elderly receive the best possible care. And we must be particularly concerned that Federal funds are properly spent. How to achieve those ends is the question we must resolve. We are holding a hearing today to review what went wrong in quality care assessment that resulted in the deaths of so many elderly residents of a long-term care facility in Texas. Was there no monitoring of the care rendered or were the standards and process blatantly ignored?

During the 97th session of Congress we discussed the need for a stringent certification process for long-term care facilities, particularly in light of the administration's suggestions to relax what may be already inadequate standards of review. This year we will consider a prospective payment proposal, DRG by popular name, to cover hospital costs reimbursed by medicare. In all of the hearings and discussions of this proposal, I have been concerned about how we will make sure that our most vulnerable citizens receive quality care and are not used or abused.

One of my efforts has been to expand opportunities for community-based alternatives for institutionalized long-term care. When our family members are cared for in their own environment, we feel reasonably secure that the best care possible will be given, since that care is under our own personal review. Providing for that level and kind of care is what my legislative initiative is all about. I fully recognize that when we place our elderly within institutions, an unavoidable event in many cases, we entrust care to a third party who hopefully is as concerned as we are in caring for a family member. But we cannot maintain that oversight, rather we depend on State or Federal authorities to certify that the care rendered meets certain standards. It is in this process that we experience problems.

In New Jersey, we have a two-tiered quality assurance mechanism for long-term care facilities, licensure and certification. Both employ onsite unannounced visits, at least annually. New Jersey uses a professional team, reviews individual patient care, and follows a set of standards more stringent than the Federal guidelines. I am pleased and assured by the process used in New Jersey but recognize that it takes commitment and resources.

Although I would hope that my own legislative proposal for community-based home health services will ultimately have the support of my colleagues as it would address some of these quality concern issues, I recognize the need to maintain and develop a suitable monitoring process that assures quality of care and prevents the human catastrophe that we will hear about today.

On Wednesday during the Senate Finance Committee hearing, I raised with Secretary Schweicker the very issue of monitoring for quality within the DRG prospective payment system. Today I express those same concerns:

What sort of quality assurance program is necessary in a prospective payment system?

How should quality monitoring be performed and by whom?

How do we assure quality within long-term care facilities?

Should quality assurance be linked to reimbursement?

Should quality assurance be a State or Federal responsibility?

Who should pay for this process?

Will quality review prevent a recurrence of this Texas tragedy?

I would hope that the witnesses appearing before the Aging Committee today will address the questions I have posed. Although we are all concerned about containing the rising cost of health care, none of us should forget that those efforts must be made without endangering the health—and very lives—of those who depend on these institutions for needed care. We cannot allow our quest to reduce the budget deficits to jeopardize the care given to our elderly.

Senator BRADLEY. I must say that as I sat here and heard this story unfold, I was somewhat sickened by the message. Of course I am anxious to hear the other witnesses, but this made me feel very uneasy about an increasing movement in America to push senior citizens into institutions of any form that are supervised by any level of government. While I know that is the direction, I nonetheless come away from this testimony with a kind of reinforced desire to see the Congress enact some kind of long-term home health care bill. If we did not have the problem of third parties dealing with elderly Americans, we might be able to make the reasonable assumption that families caring for their own members as it used to be in this country, would perhaps provide the kind of care that is a little more sensitive to the human needs of those elderly Americans.

I would hope that at some point in this Congress we might address that question more fully than we have in the past. I know the chairman has been supportive of the bill that I have introduced on

long-term home health care, but I think that the quality of home-rendered care is a very clear message from your testimony.

The second message, I think, is that the Aging Committee last year was correct in rejecting the administration's proposal toward a more lax enforcement of nursing homes, in providing a 2-year certification, and in turning over that certification process to the private sector instead of Government agencies.

Would you agree that the Aging Committee last year took the proper step, based on your experience?

Mr. MARKS. Most definitely.

Senator BRADLEY. Why?

Mr. MARKS. I believe what is needed is not a weakening in the system of enforcement, but a stronger system of enforcement. I think an example perhaps of what is taking place might provide some insight.

In 1978, there was a nursing home in Harris County, Tex., who was indicted, particular members were indicted in Harris County, for falsifying staffing records. Formally there was a form called or known as the 615 staffing form, which was required to be submitted monthly by the administrator, and this was an extensive staffing pattern report whereby the administrator had to set forth all staffing present in the facility, every day of the month, all three shifts.

Now, this present staffing report or the staffing report which I referred to was utilized until 1979. After which the requirement was dropped.

Now, it is interesting to note the parallel course of this case, this prosecution to the dropping of this particular requirement or staffing evaluation report, which I deemed to be very crucial.

Senator BRADLEY. Yes.

Mr. MARKS. When the corporation, or the particular facility was convicted shortly thereafter, and it was the basis of the conviction, the staffing report falsification, the falsification of that staffing report. Shortly thereafter, the requirement was dropped.

Now, whether this is going in relation to your question is, the GAO, I believe, did an evaluation of the Autumn Hills facility. They did not have the particular 615 report to rely on in 1980. However, nevertheless, they found I believe a large percentage of inadequate staff during a 2-week period of time. The message to me is clear: That without the very mechanisms which enable the inspectors to evaluate the care, that the problem is going to persist. There has got to be some form of evaluative indice allowing responsible governments to evaluate the services provided.

Senator BRADLEY. Let me ask you this: If the Congress doesn't act on long-term home health care bill and provide some way of keeping senior citizens out of these third-party nursing homes or even acute care hospital beds, it is government's responsibility to assure that the health and safety needs of senior citizens are met in those nursing homes. I think that you very correctly point out that it is our responsibility, under the license and certification process, which is a dual process, State and Federal, at least in my State of New Jersey.

Now, we in the Finance Committee and Congress will this year be considering a whole new approach to payment under medicare

for hospital services. It is based on establishing 467 different categories for which there will be a flat fee. If the hospital is able to provide care cheaper, it keeps the money; if more expensively, it loses the money. The goal in this process is to assure quality care in those hospitals before going to this route. In New Jersey, we have had this DRG demonstration, and we think we are working it out well. But a national program presents a whole myriad of other complexities. Based on your nursing home experience, do you think that it would make sense to make reimbursement contingent on quality care, and do you have any specific suggestions?

Mr. MARKS. Yes, sir, I do. I definitely believe that it should be corrected and I believe what has to be done is to focus upon the services necessary. There are valuable inputs but the key element here is what services are necessary for the patients, and what percent of those services are being provided.

Senator BRADLEY. Now, how would you recommend that data be transmitted? You told the story of the review visit. On that announced day, when inspectors come, all parties are prepared and everything appears all right. Past records cannot be examined; they can only look at the 3-day visit. Now, it seems to me that a first step would be the real possibility of unannounced, onsite visits and inspections.

Would you not agree?

Mr. MARKS. Yes, sir.

Senator BRADLEY. What other suggestions might you have for the transmission of data? You have developed a very comprehensive matrix. How can we be assured that that matrix will be transmitting valid data?

Mr. MARKS. All right.

One of the bases of the evaluative system developed was a comparison of resources available to demands. And for instance, you've mentioned the system in New Jersey. Well, one of the systems and tools utilized here identified, there are 66 possible services—66, maybe a few more—possible services necessary for a nursing home patient. Each patient in our particular situation was assessed, what services, what portion of those 66 services does he need? Furthermore, what staff was available then in order to meet those services.

In literally most industries across the United States, time and motion studies are being utilized. In hospitals, time and motion studies are being utilized. Validated studies exist in the United States concerning how much time it takes to provide each one of these services. It's a simple matter of plugging in the times necessary for the services, the demands necessary for the patient population and comparing it to the staffing available to determine whether it's even feasible that one of the crucial ingredients, staffing, can be met and that services can be provided.

It provides us with an evaluative indice and an objective indice by which we can make objective decisions as to the quality care, not just a subjective decision, which many times is misvalued because we are transmitting the communications from health care professionals, the governmental people, the people in government, who do not have a health care background.

People can understand objectively something is simple as a feasibility study. We have, in literally every aspect, of live evaluative

indices which are employed. You look at sports, we have batting averages as an evaluative indice, to measure the quality of a baseball player. We have even in—for used cars. We have blue books, which give us an evaluative indice——

Senator BRADLEY.What you are saying is that other than the time and motion study that you have specifically suggested, you feel that there is a way to establish an evaluative index.

Now, do you think this should be done at Federal or State level?

Mr. MARKS. At the Federal level.

Senator BRADLEY. At the Federal level?

As it is now, the Federal Government has responsibility for certification with some overlap, and the State has responsibility for licensure. Is that not correct?

Mr. MARKS. Yes, sir.

Senator BRADLEY. You think that overlapping responsibility should be retained?

Mr. MARKS. Yes, sir.

Senator BRADLEY. What do you want from the Federal Government? More than what they are not doing now?

Mr. MARKS. I think a uniform system must be developed.

Senator BRADLEY. National uniform system of quality assessment?

Mr. MARKS. Yes, sir.

Senator BRADLEY. And you have made suggestions today as to what components might be in that assessment?

Mr. MARKS. Yes, sir.

Senator BRADLEY. Do you feel that the process should be applied to nursing homes, or do you feel that the components that you have mentioned today would also be applicable to hospitals under a DRG, diagnostic related group, proposal of payments?

Mr. MARKS. Well, I'm——

Senator BRADLEY. You don't know about that?

Mr. MARKS. Yes, sir.

Senator BRADLEY. OK. You would just leave it in nursing homes?

Mr. MARKS. Yes.

Senator BRADLEY. Thank you very much.

Mr. MARKS. Thank you.

Chairman HEINZ. Senator Melcher.

Senator MELCHER. Thank you, Mr. Chairman.

Mr. Marks, I read your testimony, and I listened to your comments or answers to the questions, and your suggestions.

Senator BRADLEY. Would the Senator yield just for a minute?

Senator MELCHER. Yes; I would be glad to.

Senator BRADLEY. If I could say to the chairman, I will have to leave. I won't be able to remain, but I did want to at least welcome the two New Jersey witnesses to the committee. I know the committee will benefit from their testimony about what is being done correctly in New Jersey.

Thank you.

Senator MELCHER. Mr. Marks, this following up, the following up of the answers to the questions made by other Senators, this interfacing of Federal regulations with State regulations, from your experience, has not worked in Texas; is that correct?

Mr. MARKS. That's correct.

Senator MELCHER. Now, does the method of correction that you have suggested, how do you get away from that interfacing of Federal and State regulations to make sure that it does work? I mean, what's the watchdog here or what's the enforcing arm, or what really—how can you be sure if those suggestions were followed that there would be enforcement?

Mr. MARKS. Well, one of the things which I believe is crucial is that there must be an evaluation of the evaluators. The Federal Government in supplying, or the fact that $24.2 billion is supplied in the care of nursing home patients has a definite interest to see that those agents, those local departments of health who are supposed to be monitoring, are indeed doing just that. And our—hopefully, if a national system was developed which would allow comparison from one home, one State to another, hopefully that the national system was being implemented uniformly.

Senator MELCHER. All right. In other words, progress, uniformity, hopefully enforcement.

Mr. MARKS. You have to, I believe, and this case is a fine illustration. Someone has to take note and measure the quality of the assessment. In pursuing this case, I have contacted experts all across the United States, geriatric experts, and in communicating to them the reports of the Texas Department of Health, they are almost uniformly—almost uniformly their initial question has been: What in the world is the allegiance of the Texas Department of Health to this facility? Someone has to, or I believe the Federal Government has to somehow monitor and assure itself that those people who are acting as its agents are, in fact, performing.

Senator MELCHER. Well, in this particular investigation you are involved with, the results that you have indicated so far have been devastatingly minimal; is that correct?

Mr. MARKS. Yes, sir.

Senator MELCHER. You have made in your testimony, in your prepared testimony, a comparison or an allusion to the victim. If the victim had been an infant, the results would have been different.

Mr. MARKS. Yes, sir.

My remarks in that vein were that the criminal justice system would have regarded the case in a different light.

Senator MELCHER. In other words, the criminal justice system is geared to protecting infants but not necessarily geared to protecting the elderly in nursing homes?

Mr. MARKS. I don't know so much about geared to protecting infants as opposed to elderly nursing home patients, but I think that the—for some reason that the two victims, if you will, hypothetical victims, are treated differently. I do not think that in this particular case had there been 56 infants who died, who were covered with ulcerated, puss-infested sores, that a plea bargain would in any way have been considered in this case; whereas, what took place was that a plea bargain was considered. Why? I could not help but come to the conclusion that it is the—perhaps the difference in the way society regards elderly nursing home patients.

Senator MELCHER. Well, it is tragic if in our society we have taken the attitude that infants must live because they have a

whole life ahead of them, but the elderly must die because their life is over with. Yet, your testimony suggests that to be the case.

Now, I tend to believe that that is the case. I tend to believe that what you have experienced in this investigation is only one of a series that has been going on for over a generation in nursing homes, that the elderly are somehow expected to die, and therefore their needs are not to be as dramatically protected as we protect the other age group. But that seems to me to be entirely contradictive to the 14th amendment which supplies the equal protection of the law to all citizens.

What should be the penalty? Should it be a Federal penalty? Are there criminal penalties separate and distinct from just decertification? Could that be one of the tools that is used in this entire process and to be properly identified as a penalty in order to get compliance?

Mr. MARKS. Well, criminally, in the State of Texas at least, the laws allow for the prosecution of nursing homes and agents who do not comply with the mandates of Congress, who do not provide safe and adequate care.

An individual in the State of Texas who causes the death of a resident in a nursing home can be prosecuted for murder and is subject to the same penalties as any individual is.

Senator MELCHER. I understand that. That's basic and elementary in all State law and is elementary in our Constitution, but your experience is that it hasn't been applied. And I think it is fair to say that during the last 10 years and at least the last dozen years there has been plenty of investigation by Congress that indicates indeed that it has not been applied in many instances. Now, there seems to be a breakdown in the social mores and the consciousness of the country itself, that somehow the acts that contribute to an individual's death are not applied the same in nursing homes for the elderly.

And my question is specifically based on your own experience: How tough should the penalty be? In other words, the Federal penalty is not there just by decertifying.

Mr. MARKS. Yes, sir.

I don't think the penalty can be tough enough for the things which occurred at the Autumn Hills' facility.

Now, as I mentioned earlier, I believe what needs to be done is something must be done in the enforcement area. Perhaps some type of Federal branch of the Justice Department assigned solely to look at cases such as this. The problem in a small district attorney's office when a case such as this is presented is when the victim or the family member of the victim comes in, the response is, that sounds like a civil case. We handle rapes, murders, one-shot shooting. This is just over and beyond what we are capable of performing. We don't have the medical, the nursing knowledge, to look into, investigate, and put together a case like this. And yet, under the Texas law, any complaint of the abuse and neglect are transmitted to the district attorney's office for some form of disposition.

I think the problem is perhaps highlighted by the remarks of the comissioner of health of the State of Texas, who commented that, I believe in 1979, he transmitted some 58, 59 cases of recommended

neglect to district attorney's offices across the State of Texas with no action. Someone, I believe, has got to develop some background in this particular area and assign solely to inquiry, and to enforce the existing law. Just as we have divisions for Federal fraud, there must be, I believe, a division created for nursing home abuse.

Senator MELCHER. I think that's the most meritorious and worthwhile suggestion we could have. We have divisions within the Justice Department dedicated to continuing an ongoing presence in water law, and in public land law, and in various types of fraud and criminal activity, as well as in antitrust law. Surely the elderly are worth an ongoing division, an ongoing entity, within the Justice Department to protect them, because it's obvious that we have received testimony like yours in various committees of Congress, to my knowledge, for at least a dozen years, and it is an area that is not being protected. The elderly should be protected, they still are people, and they still have, under the 14th amendment of the Constitution, the same protection as all other age groups.

Thank you very much, Mr. Marks.

Mr. MARKS. Thank you.

Chairman HEINZ. Mr. Marks, I've just got one last question for you, and it's really a personal one.

Why, after everybody in the State of Texas that had responsibilities in this area, be they regulators or law enforcement people, seem to have ignored the Autumn Hills nursing home, did you individually take it upon yourself to get involved? What motivated you, why did you do it?

Mr. MARKS. I believe it was initially my exposure to a very grave set of circumstances, the longevity of the conduct, the extensiveness, and the seriousness of it. Second, I guess, as a personal note, I have always been and perhaps always will be attracted to those occasions and those causes wherein the victim appears to have the smallest voice, where there appears to be no advocate. And I was more than willing to be that for these people.

Chairman HEINZ. Well, your testimony has been extremely helpful. As Senator Bradley said, it is a distressing situation, a depressing example, but hopefully out of the distress that you have highlighted here in a variety of ways, this committee and our colleagues in the Senate will be able to bring about a better system than either the one we have now, or the one we hope to move to.

We are deeply indebted to you. Thank you very much.

Mr. MARKS. Thank you, sir.

CHART 1

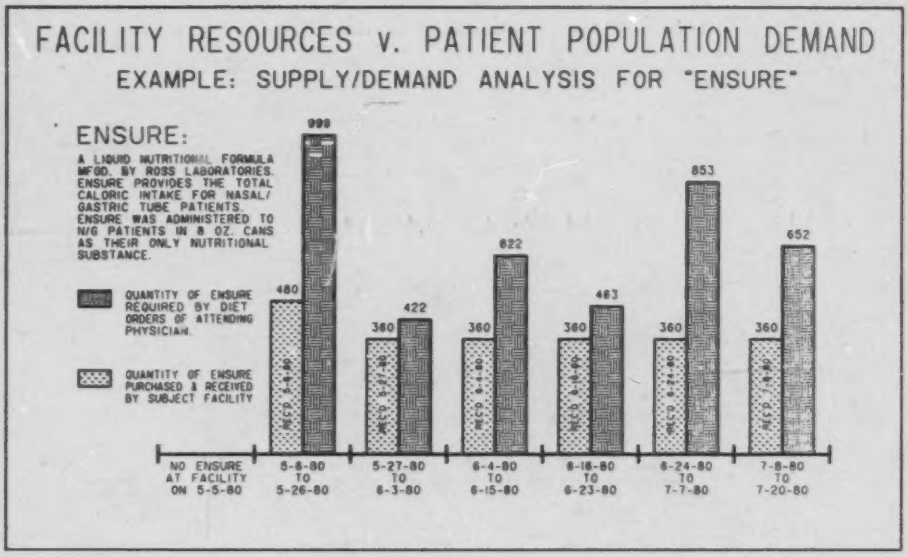

FACILITY RESOURCES v. PATIENT POPULATION DEMAND
EXAMPLE: SUPPLY/DEMAND ANALYSIS FOR "ENSURE"
ENSURE:
A LIQUID NUTRITIONAL FORMULA MFGD. BY ROSS LABORATORIES. ENSURE PROVIDES THE TOTAL CALORIC INTAKE FOR NASAL/GASTRIC TUBE PATIENTS. ENSURE WAS ADMINISTERED TO N/G PATIENTS IN 8 OZ. CANS AS THEIR ONLY NUTRITIONAL SUBSTANCE.
QUANTITY OF ENSURE REQUIRED BY DIET ORDERS OF ATTENDING PHYSICIAN.
QUANTITY OF ENSURE PURCHASED & RECEIVED BY SUBJECT FACILITY
480
999
360
422
360
622
360
483
360
853
360
652
NO ENSURE AT FACILITY ON 5-5-80
5-6-80 TO 5-26-80
5-27-80 TO 6-3-80
6-4-80 TO 6-15-80
6-16-80 TO 6-23-80
6-24-80 TO 7-7-80
7-8-80 TO 7-20-80

CHART 2

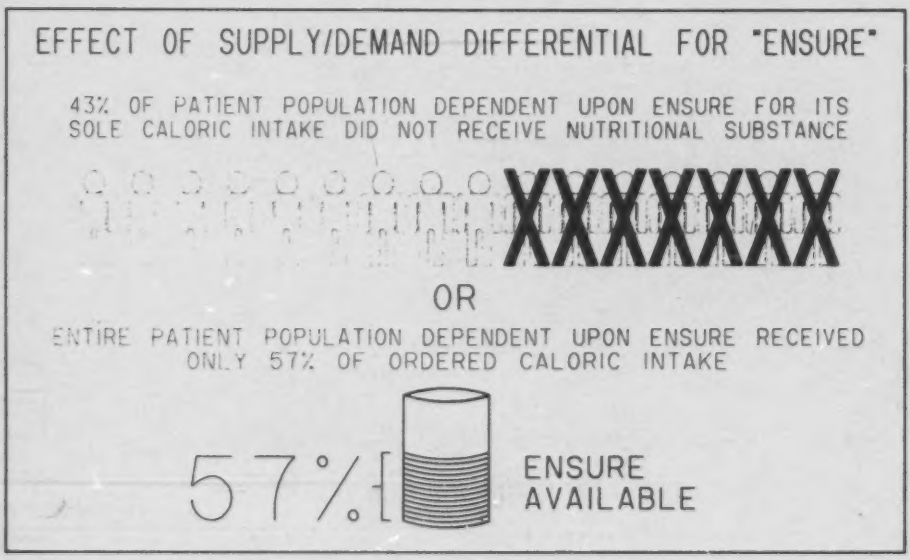

EFFECT OF SUPPLY/DEMAND DIFFERENTIAL FOR "ENSURE"
43% OF PATIENT POPULATION DEPENDENT UPON ENSURE FOR ITS SOLE CALORIC INTAKE DID NOT RECEIVE NUTRITIONAL SUBSTANCE
XXXXXXX
OR
ENTIRE PATIENT POPULATION DEPENDENT UPON ENSURE RECEIVED ONLY 57% OF ORDERED CALORIC INTAKE
57%
ENSURE AVAILABLE

CHART 3

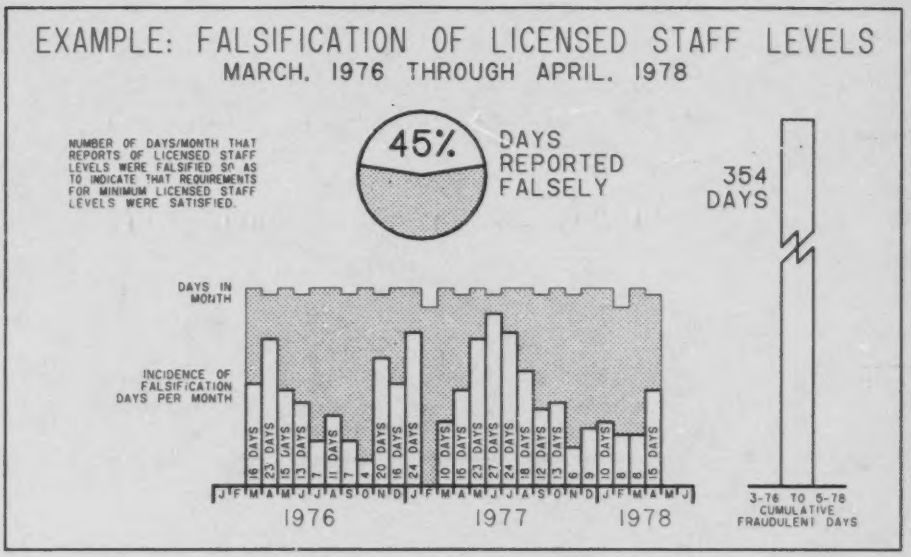


CHART 4

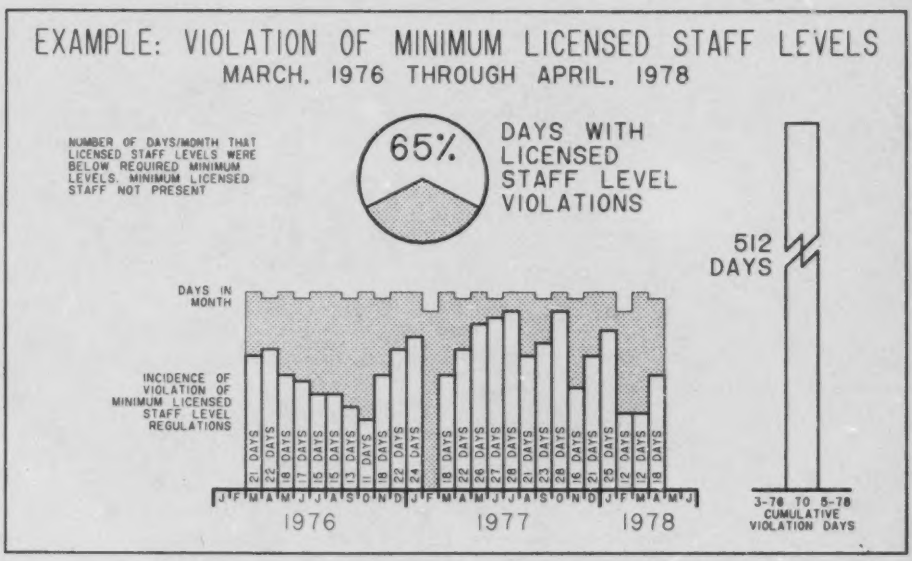


CHART 5

SANCTIONS IMPOSED FOR POOR PATIENT CARE
1-1-78 TO 8-31-79 OR 571 POSSIBLE DAYS

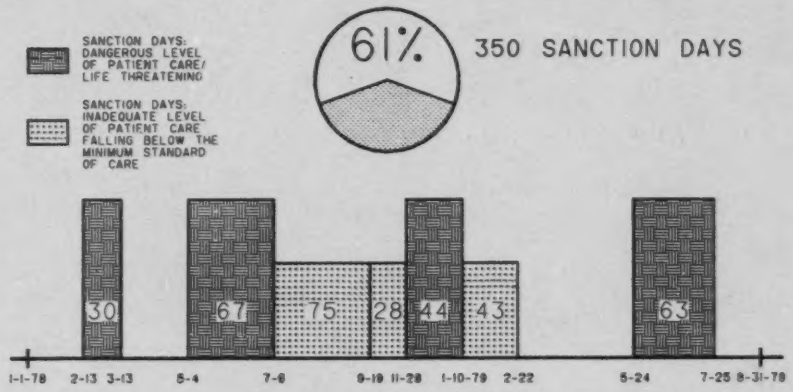


CHART 6

MEDICAID REVENUE SCHEDULE FOR SUBJECT FACILITY
CAPACITY: 120 LICENSED BED FACILITY

	PATIENT DAYS			PATIENT GROSS REVENUE		
	1976	1977	1978	1976	1977	1978
MEDICAID. LEVEL 4 PATIENTS	3924	2859	3627	0 03046	67667	92234
MEDICAID. LEVEL 3 PATIENTS	29163	30610	27011	531112	583812	560725
MEDICAID. LEVEL 2 PATIENTS	1533	2353	3250	22302	35125	60990
PRIVATE PAY/OTHER PATIENTS	8876	7662	5051	162921	154907	116258
TOTALS	43296	43484	38939	0799381	841521	830207

% MEDICAID PATIENT DAYS			% MEDICAID REVENUES		
1976	1977	1978	1976	1977	1978
80%	82%	87%	80%	82%	86%

CHART 7

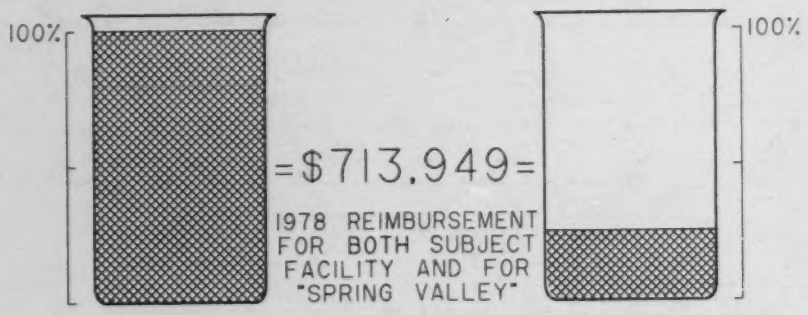
COMPARISON: SUBJECT FACILITY v. "SPRING VALLEY"

"SPRING VALLEY" IS A HYPOTHETICAL FACILITY WITH A PATIENT POPULATION COMPARABLE TO THAT OF THE SUBJECT FACILITY. "SPRING VALLEY" DELIVERED 100% OF THE CONTRACTED FOR SERVICES.

	1976	1977	1978
"SPRING VALLEY" MEDICAID REIMBURSEMENT	$636460	$686614	$713949
SUBJECT FACILITY ACTUAL MEDICAID REIMBURSEMENT	$636460	$686614	$713949
RATIO: SUBJECT FACILITY MEDICAID REVENUE / "SPRING VALLEY" MEDICAID REVENUE	100%	100%	100%
FINANCIAL PENALTY IMPOSED BY INSPECTION AGENCY FOR LEVEL OF CARE PROVIDED BY SUBJECT FACILITY	$ 0	$ 0	$ 0

CHART 8

INTERRELATIONSHIP: SERVICES PROVIDED v. MEDICAID REVENUE



1978 % OF CONTRACTED SERVICES PROVIDED BY HYPOTHETICAL "SPRING VALLEY"

1978 % OF CONTRACTED SERVICES PROVIDED BY SUBJECT FACILITY

CHART 9

INDUSTRY COMPARISONS: NET PROFIT, RETURN ON EQUITY

INDUSTRY GROUP	1979 NET PROFIT MARGIN	1979 RETURN ON EQUITY
INTEGRATED PETROLEUM: (MOBIL,EXXON,GULF,CONOCO,ETC)	7.5%	22.9%
RETAIL STORES. (SEARS,KMART,JC PENNEY,ETC)	3.2%	12.2%
NATURAL GAS: (EL PASO,HOUSTON NATURAL, TENNECO,TEXAS EASTERN,ETC)	5.6%	14.7%
FAST FOOD: (CHURCH'S,PIZZA INN, MACDONALDS,DUNCAN,ETC)	4.4%	14.4%
TEXAS BANKING: (SW BANCSHARES,REP OF TEXAS, MERCANTILE,TEXAS COMMERCE)	--	15.3%
MEDICAL SERVICES: (CENCO,BEVERLY ENTERPRISES, NATL MED ENTERPRISES,ETC)	5.7%	16.7%
758 PROPRIETARY NURSING HOMES IN TEXAS	5.4%	33.8%

DATA ON TEXAS NURSING HOMES FROM TEXAS DEPARTMENT OF HUMAN RESOURCES
ALL OTHER DATA FROM VALUE LINE INVESTMENT SURVEY. ARNOLD BERNHARD INC

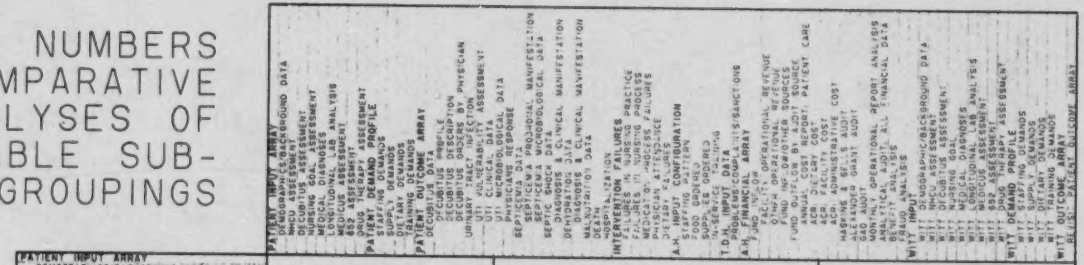
CHART 10

MAJOR ANALYTICAL CATEGORY MATRIX

	PATIENT INPUT	PATIENT DEMAND PROFILE	PATIENT OUTCOME ARRAY	INTERVENTION FAILURES	A·H· INPUT CONFIGURATION	T·D·H· INPUT DATA	A·H· FINANCIAL ARRAY	WITT INPUT DATA	WITT DEMAND PROFILE	WITT OUTCOME ARRAY
PATIENT INPUT										
PATIENT DEMAND PROFILE										
PATIENT OUTCOME ARRAY										
INTERVENTION FAILURES										
A·H· INPUT CONFIGURATION										
T·D·H· INPUT DATA										
A·H· FINANCIAL ARRAY										

CHART 11

SHEET NUMBERS FOR COMPARATIVE ANALYSES OF VARIABLE SUB-GROUPINGS



1A	1B	1C
2A	2B	2C
3A	3B	3C
4A	4B	4C
5A	5B	5C

Chairman HEINZ. Our next witness is Michael Zimmerman. Mr. Zimmerman, please identify yourself and your associates, and please proceed.

STATEMENT OF MICHAEL ZIMMERMAN, WASHINGTON, D.C., ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY JAMES BARNETT, DALLAS, TEX., REGIONAL OFFICE, GAO; AND ROBERT IFFERT, HEALTH CARE FINANCING ADVISER, GAO

Mr. ZIMMERMAN. I certainly will. Mr. Chairman, my name is Michael Zimmerman, I am an Associate Director of the Human Resources Division of the General Accounting Office; and to my right is Jim Barnett of our Dallas regional office. Mr. Barnett was responsible for the audit work at Autumn Hills. To my left is Robert Iffert. Bob is our Health Care Financing Adviser, and he is quite knowledgeable on medicaid reimbursement practices.

Mr. Chairman, members of the committee, we are pleased to be here today to discuss certain features of the prospective payment systems developed by various State medicaid programs to pay nursing homes, particularly the system developed by the State of Texas and discussed in our October 14, 1982, report on Autumn Hills.

For fiscal year 1981, medicare reimbursements to the 5,000 skilled nursing facilities participating in that program were about $400 million. In contrast, medicaid payments to the 7,300 skilled nursing facilities participating in that program were about $4 billion, and another $7 billion in payments were made to the several types of intermediate care facilities. Thus, medicaid is clearly the predominant public payer of nursing home services.

As of late 1982, at least 36 States had some type of cost-based prospective system in place, to pay for these services.

The Tax Equity and Fiscal Responsibility Act of 1982 provides that HHS, in consultation with the Senate Committee on Finance and the House Committee on Ways and Means, shall develop proposals for legislation, which would provide that hospitals, SNF's, and, to the extent feasible, other providers be reimbursed prospectively under medicare. The proposals were to be provided to these committees by December 31, 1982.

Although the department provided a report to the Congress in December 1982, concerning a proposed prospective payment methodology for hospitals under medicare, we understand that a companion proposal for prospective payments to SNF's is still being developed.

In view of the States' broad experience in developing and using prospective payment systems, we believe that their systems should be seriously looked at in developing a Federal system.

The current Texas medicaid payment system for nursing homes, which went into effect January 1, 1979, prospectively develops per diem payment rates which are uniform statewide for each level or class of nursing home care. All homes in the State receive payment based on the same rates for each respective day of skilled—and the two levels of intermediate—care provided.

The per diem rates are determined by using financial and statistical information from annual cost reports submitted by about 900

participating facilities. The costs are adjusted for various factors, such as minimum occupancy rates and inflation. These adjusted costs are then divided into four categories—patient care, dietary, facility, and administrative cost. The patient care costs are further subdivided into the three levels of care. The actual per diem rates for each level of care are determined by selecting the 60th percentile cost from the appropriate patient care cost array and the dietary, facility, and administrative cost arrays and summing them up to arrive at the statewide base rate.

In our opinion, this ratesetting methodology makes it very difficult for individual homes or small groups of homes to manipulate the system to receive higher medicaid payments by overstating or inflating reported allowable costs. The insensitivity of the system to unallowable costs is illustrated by the results of the State's and our own audits of Autumn Hills' costs.

The State had audited the 1978 cost reports for the 17-facility Autumn Hills' chain, 13 of which had been included in the data used to set the statewide rates for the period January 1 through August 31, 1980. The State identified unallowable costs of about $204,000, including $187,000 in unallowable administrative costs. However, because the Autumn Hills' homes were over the 90th percentile on the data arrays, none of these unallowable costs affected the State's payment rates set at the 60th percentile.

Similarly, our audit of the 1980 central office costs, which were included in the data to set the rates for the period beginning in September 1981, identified about $250,000 in unallowable, questionable, or undocumented costs, but, again, because Autumn Hills' facilities were above the 80th percentile on the data arrays for administrative costs, none of these questionable costs affected the State's payment rates.

The major area of concern I have with these relatively significant amounts of questionable costs is that the money was apparently not being spent on patient care.

Another area of concern is that the Texas ratesetting methodology is insensitive both to the costs associated with the needs of individual patients within the three broad levels of care and to the case mix of individual facilities. This could provide incentives to restrict access for those patients needing more expensive care.

In our view, a nursing home financial auditing system should be designed to support the payment system a State elects to adopt. In Texas, the ratesetting methodology minimizes the number of nursing home audits needed because the costs of the facilities around the 60th percentile actually determine the rates. We see little benefit in terms of reducing costs from auditing facilities near the bottom or top of each array, because these facilities will have little opportunity to affect the rates regardless of the allowability of costs they report or the audit results.

In our October 1982 report, we recommended that Texas concentrate its nursing home audit activities on the facilities grouped around the 60th percentile levels of each data array since the costs reported by those homes are likely to affect the accuracy of the State's per diem rates.

It appears that a prospective payment system can contribute to restraining the increase in nursing home costs by providing an in-

centive for facilities to operate within the preestablished payment rates. On the other hand, this same incentive places an increased obligation on the responsible Federal and State agencies to insure that patients are receiving care that meets the appropriate standards for quality. One possible approach to achieving this objective would be to adopt a system of financial penalties for facilities providing substandard care as determined through the existing quality control programs. Several States have adopted such a payment approach.

In 1979, the Texas Health Department, which conducts nursing home inspections, began a system of grading individual nursing homes annually to identify and recognize those that were deemed superior. Fifteen of the 17 Autumn Hills' homes have received superior ratings in at least 1 year over the period 1979 to 1981. Three homes were rated superior all 3 years, but two have never received a superior rating. One of the latter was the Texas City home that we were asked to audit. This home, which was one of the higher cost homes in the chain in the patient-care category, has had a history of lack of compliance with medicaid health and safety standards.

The State withheld medicaid payments to the facility on four occasions during 1978 and 1979 for serious health and safety deficiencies and the failure to correct them. In fact, the health department had recommended that the facility be excluded from the medicaid program in August 1979, but decided not to exclude it after the home made a number of improvements. Among the problems was a shortage of licensed nurses on duty to meet the various State and Federal staffing standards. The shortages occurred in 52 percent of the days tested by the State in 1978, and 14 percent of the days tested in 1979. For 1980 and 1981, the State identified no shortages. We examined nurses' timecards for January, June, and October 1980, which were different periods than the State tested that year, and identified 32 days where shortages occurred, principally in the ICF section.

Autumn Hills has strongly disputed our findings by pointing out that in the aggregate, for the periods we reviewed, the facility had more than enough licensed nursing personnel to meet the State's minimum staffing standards. However, we do not believe that the aggregate number of nurses is the issue. We believe that the issue is whether for each day, for each part of the facility, and for each shift, the appropriate number of licensed nursing personnel were on duty to meet the State's minimum standards.

In light of Autumn Hills' comments, we have reexamined the timecards from which the nurses were paid and concluded that our findings are essentially accurate.

This concludes my statement. We will be pleased to answer any questions the committee may have.

[The prepared statement of Mr. Zimmerman follows:]

PREPARED STATEMENT OF MICHAEL ZIMMERMAN

Mr. Chairman and members of the committee, we are pleased to be here today to discuss certain features of the prospective payment systems developed by various State medicaid programs to pay nursing homes, particularly the system developed by the State of Texas and discussed in our October 14, 1982, report entitled "Audit

of Medicaid Costs Reported by Autumn Hills Convalescent Centers, Inc., Houston, Texas."

My testimony today will focus on four issues. First, in contrast to the Federal medicare program which continues to reimburse skilled nursing facilities (SNF's) retrospectively based on actual allowable incurred costs, about 36 States have adopted some form of prospective system, in which the payment rates for a particular period are set in advance based on costs incurred during a prior period. Because, in 1982, Congress mandated that the Department of Health and Human Services develop legislative proposals to provide for reimbursing SNF's prospectively under medicare, and because medicaid is the dominant governmental payer for nursing home care, we believe that these existing State systems should be seriously looked at when developing the Federal medicare system.

Second, under the system developed in Texas, the per diem rates are determined on a statewide basis and are extremely insensitive to the costs reported by individual facilities. Thus, it is highly unlikely that a facility or small group of facilities can manipulate the system to receive higher medicaid payments by overstating or inflating reported costs. This was illustrated by our audit of the Autumn Hills' central office costs in which we questioned about $250,220 (or about 18 percent) of $1.4 million total costs reported there. None of the costs we considered unallowable or questionable had any impact on what the company and other nursing homes in the State were paid under the State's ratesetting methodology. On the other hand, this methodology is not sensitive to the costs associated with the needs of individual patients.

Third, certain prospective payment systems, such as in Texas, can lessen somewhat the need for financial audits as compared with the retrospective systems, which reimburse each facility based on its allowable incurred costs. Prospective systems do not eliminate the need for such audits, but the audits should be designed and implemented to support the reimbursement methodology a State chooses to employ.

Finally, and most important, prospective payment systems, such as in Texas, can apparently succeed in restraining rising health care costs by providing an incentive for nursing homes to operate within the overall rates. This same incentive also creates a greater need for the States to review and monitor the quality of patient care being provided. Because direct patient care represents the largest component of costs, it provides the greatest opportunity for cost reductions. Therefore, it is essential that cost savings not be achieved by providing care that fails to meet program standards.

EXTENT OF PROSPECTIVE PAYMENT SYSTEMS UNDER MEDICAID

For fiscal year 1981, medicare reimbursements to the 5,000 SNF's participating in that program were about $400 million. In contrast, medicaid payments to the 7,300 SNF's participating in that program were about $4 billion, and another $7 billion in payments were made to the several types of intermediate care facilities (ICF's). Thus, medicaid is clearly the predominant public payer of nursing home services.

As of late 1982, at least 36 States had some type of cost-based prospective system in place to pay for these services. Attached as an appendix to my statement is a summary analysis of the principal types of nursing home reimbursement systems employed by 49 States and the District of Columbia.[1] It should be recognized, however, that under the broad classification of prospective payment systems, the ratesetting methodologies used vary widely.

Section 101(c)(3) of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) provides that the Department of Health and Human Services, in consultation with the Senate Committee on Finance and the House Committee on Ways and Means, shall develop proposals for legislation which would provide that hospitals, SNF's, and to the extent feasible, other providers be reimbursed prospectively under medicare. The proposals were to be provided to these committees by December 31, 1982.

Although the Department provided a report to the Congress in December 1982, concerning a proposed prospective payment methodology for hospitals under medicare, we understand that a companion proposal for prospective payments to SNF's is still being developed.

In view of the States' broad experience in developing and using prospective payment systems we believe that their systems should be seriously looked at in developing a Federal system.

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[1] Arizona not included.

In this regard, section 249(b) of the Social Security Amendments of 1972 authorized the Department to use the SNF medicaid rates in any State as the basis for making medicare payments to such facilities, with appropriate increases for the items or services covered by medicare but not included in the State rates. One purpose of this provision was to enable medicare to move toward prospective payment for nursing home services to lessen the substantial auditing and cost-reporting expenses associated with medicare's retrospective system. However, medicare has never used this authority as a basis for paying nursing homes.

THE TEXAS NURSING HOME SYSTEM AND RATESETTING METHODOLOGY

The current Texas medicaid payment system for nursing homes, which went into effect January 1, 1979, prospectively develops per diem payment rates which are uniform statewide for each level or class of nursing home care. All homes in the State receive payment based on the same rates for each respective day of skilled and the two levels of intermediate care provided.

The per diem rates are determined using financial and statistical information from annual cost reports submitted by about 900 participating facilities. The costs are then adjusted for various factors, such as minimum occupancy rates and inflation. These adjusted costs are then divided into four categories—patient care, dietary, facility, and administrative cost—and the patient care costs are further subdivided into the three levels of care. The actual per diem rates for each level of care are determined by selecting the 60th percentile cost from the appropriate patient care cost array and the dietary, facility, and administrative cost arrays and summing them to arrive at the statewide base rate.

In our opinion, this ratesetting methodology makes it very difficult for individual homes or small groups of homes to manipulate the system to receive higher medicaid payments by overstating or inflating reported allowable costs. For example, even if the home at the 60th percentile included unallowable or inflated costs, the net effect on the rate would depend on the adjusted cost of the facility immediately below it on the data array—which, when rounded to the nearest penny, would likely be the same. The insensitivity of the system to unallowable costs reported by individual facilities is illustrated by the results of the State's and our audits of Autumn Hills' costs.

The State had audited the 1978 cost reports for the 17-facility Autumn Hills' chain, 13 of which had been included in the data used to set the statewide rates for the period January 1 through August 31, 1980. The State identified unallowable costs of about $204,000, including $187,000 in unallowable administrative costs; however, because the Autumn Hills' homes were over the 90th percentile on the data arrays, none of these unallowable costs affected the State's payment rates set at the 60th percentile. Similarly our audit of the 1980 central office costs, which were included in the data to set the rates for the period beginning in September 1981, identified about $250,000 in unallowable, questionable, or undocumented costs, but again, because Autumn Hills' facilities were above the 80th or 90th percentiles on the data arrays for administrative costs, none of these questionable costs affected the State's payment rates.

The major area of concern associated with these relatively significant amounts of unallowable or questionable costs is that the money was apparently not being spent on patient care.

Another area of concern, of course, is that the Texas ratesetting methodology is insensitive both to the costs associated with the needs of individual patients within the three broad levels of care and to the case mix of individual facilities. This could provide incentives to restrict access for those patients needing more expensive care.

FINANCIAL AUDITS SHOULD BE DESIGNED TO SUPPORT THE STATES' RATESETTING METHODOLOGY

As indicated the States have adopted a wide range of reimbursement or payment systems to pay for nursing home care. In our view, a nursing home financial auditing system should be designed to support the payment system a State elects to adopt. In Texas, the ratesetting methodology minimizes the number of nursing home audits needed because the costs of only a relatively few facilities around the 60th percentile actually determine the rates. We see little benefit, in terms of reducing costs, from auditing facilities near the bottom or top of each array because these facilities will have little opportunity to affect the rates regardless of the allowability of costs they report or the audit results.

In the past, the State has not taken advantage of this situation in developing its audit plans. This resulted in part from the Federal medicaid regulations, effective in

January 1978, which required the State to audit all participating nursing homes by the end of calendar year 1980 and 15 percent each year thereafter. The Omnibus Budget Reconciliation Act of 1981 modified these financial auditing requirements to give the States more flexibility. In our view, in these times of scarce Federal and State dollars, it is even more important that the costs of administering and auditing these programs be focused on areas that can produce the most cost-beneficial results.

In our October 1982 report, we recommended that this could be accomplished under the Texas nursing home program if the State were to concentrate its nursing home audit activities on the facilities grouped around the 60th percentile levels of each data array since the costs reported by this group of homes are more likely to affect the accuracy of the State's per diem rates.

NEED TO MAINTAIN APPROPRIATE STANDARDS OF QUALITY

Since the current prospective payment system in Texas was put into effect in January 1979, the per diem rates have increased by an average of about 6 percent a year. By way of contrast, in Massachusetts, which employs primarily a retrospective reimbursement system, the rate of increase has been about 10 percent a year since 1979. Thus, it appears that a prospective payment system can contribute to restraining the increase in nursing home costs by providing an incentive for operators to minimize their costs so as to operate within the preestablished payment rates. On the other hand, this same incentive places an increased obligation on the responsible Federal and State agencies to insure themselves that patients are receiving care that meets the applicable standards for quality. One possible approach to achieving this objective would be to adopt a system of financial penalties for facilities providing substandard care as determined through appropriate quality control programs such as periodic inspections and utilization control mechanisms which are required under existing law. Several States have adopted such a payment approach.

QUALITY OF CARE PROBLEMS ASSOCIATED WITH THE TEXAS CITY HOME

The Autumn Hills' chain operated 17 nursing homes in 13 cities located principally in southeast and central Texas.

In 1979, the State health department, which conducts the nursing home inspections, began a system of grading individual SNF and ICF sections of nursing homes annually to identify and recognize those that were deemed superior. Fifteen of the Autumn Hills' homes have received superior ratings in at least 1 year over the period 1979 to 1981. Three homes were rated superior all 3 years, but two have never received a superior rating. One of the latter was the Texas City home that we were asked to audit because of allegations of poor patient care. This home consisted of two distinct parts—one for each of two levels of care consisting of 60 SNF beds in one wing and 60 ICF beds in another.

The Texas City home, which was one of the higher cost homes in the chain in the patient care category, has had a history of lack of compliance with medicaid health and safety standards.

The State withheld medicaid payments to the facility on four occasions during 1978 and 1979 for serious health and safety deficiencies and the failure to correct them. In fact, the health department had recommended that the facility be excluded from the medicaid program in August 1979, but decided not to exclude it after the home made a number of improvements. Among the problems was a shortage of licensed nurses on duty to meet the various State and Federal staffing standards. The shortages occurred in 52 percent of the days tested by the State in 1978, and 14 percent of the days tested in 1979. For 1980 and 1981, the State identified no shortages. We examined timecards for January, June, and October 1980—which were different periods than the State tested that year—and identified 32 days where shortages occurred, principally in the ICF section.

Autumn Hills has strongly disputed our findings in this regard by pointing out that in the aggregate, for the periods we reviewed, the facility has more than enough licensed nursing personnel to meet the State's minimum staffing standards. However, we do not believe that the aggregate number of nurses is the issue. We believe that the issue is whether for each day, for each distinct part (SNF and ICF), and for each shift, the facility had the appropriate licensed nursing personnel on duty to meet the State's miminum standards.

In light of Autumn Hills' comments, we have reexamined these timecards, which were the basis on which the nurses were paid, and concluded that our findings were essentially accurate.

This concludes my formal statement, and we would be pleased to respond to any questions the committee may have.

Appendix I

NUMBER OF STATES USING VARIOUS TYPES OF REIMBURSEMENT SYSTEMS UNDER THEIR MEDICAID NURSING PROGRAMS AS OF LATE DECEMBER 1982

Types of reimbursement system	Types of facilities		
	Skilled nursing facilities	Intermediate care facilities	Intermediate care facilities for mentally retarded
Prospective	31	34	29
Retrospective	14	11	17
Combination[1]	2	2	2
Negotiated[2]	3	3	2

[1] Some categories of costs are paid for on a prospective basis and others are reimbursed on a retrospective basis.
[2] Although cost-based, the rates are not based on a specific formula or methodology, but are negotiated with the industry.
Source: State plans on file at Health Care Financing Administration.

Appendix II

PRINCIPAL TYPES OF REIMBURSEMENT SYSTEMS USED BY THE STATES UNDER THEIR MEDICAID NURSING HOME PROGRAMS AS OF LATE DECEMBER 1982

Prospective.—Alabama, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Illinois, Indiana, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, New York, North Carolina, North Dakota, Rhode Island, South Carolina, Texas, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

Retrospective.—Alaska, Hawaii, Idaho, Iowa, Maine, Maryland, Massachusetts, Montana, New Hampshire, New Mexico, Oregon, Pennsylvania, Tennessee, and Vermont.

Combination.—Nevada and Ohio.

Negotiated.—Oklahoma, South Dakota, and Utah.

NOTE.—Based on method of paying skilled nursing facilities.

Chairman HEINZ. Mr. Zimmerman, thank you very much. First, a point of clarification. On page 11 of your statement, you note that in 1980–81 the State identified no shortages of licensed nurses on duty; you identified the timecards yourselves, you examined the timecards yourselves for 3 months to spot check in 1980, and found 32 out of 90 days, one-third, where there were shortages.

How could the State find that there were no shortages?

Mr. ZIMMERMAN. Well, let me say this: We examined a different period, and so there was no overlap in period. But I might ask Mr. Iffert to elaborate on the basis that he sees for the difference.

Mr. IFFERT. Well, one possible difference—I really don't know—could be that historically the State shows up for its annual inspections the same time every year, 1978, 1979, 1980.

Chairman HEINZ. Like the swallows returning to Capistrano.

Mr. IFFERT. Well, I don't know if they are swallows. They return to Capistrano at the same time.

Chairman HEINZ. And everybody down there waiting for them.

Mr. IFFERT. Yes.

Chairman HEINZ. I'm told that one of the reasons the State didn't know about this is they abolished the form on which it had been reported in previous years, is that true?

Mr. IFFERT. We have a number of those forms in our workpapers, and we were focusing on 1980, so I really can't confirm that. I think Mr. Marks is referring to the X-15.

Chairman HEINZ. Maybe you could just check into that, because I understand that one of the reasons it didn't show up is that they stopped the reporting system that caused it to show up.

Mr. IFFERT. Well, maybe I can clarify that a little bit. As for verification, the State did not rely on the forms; when they make their annual survey, they look at staffing for a 3-week period, they use essentially the same methodology that we did, which is the timecards that were used in the payroll system. And then you can tie that in with timeclocks as to who was actually where at the time.

[Subsequent to the hearing, Mr. Iffert submitted the following information:]

The form referred to is the quarterly staffing report—State form X-15 (formerly form 615), which the nursing homes are required to submit to the Texas Department of Health setting forth from payroll records the names and types of personnel on each tour of duty during at least 1 week each calendar quarter. The week is to be selected by the department of health. This procedure was effective April 1, 1979, and replaced the requirement that nursing homes make monthly submissions of the X-15. This change was in accordance with Federal regulations (42 CFR 431.610(g)).

Chairman HEINZ. Now, Mr. Zimmerman, you have questioned the appropriateness of $250,000 of Autumn Hills' expenditures. That was about 18 percent of total expenditures during that particular period of time, a very significant amount of money proportionate to that which was expended.

What was the nature of the kind of costs disallowed, were they travel, personal—what were they?

Mr. ZIMMERMAN. Well, as you may also recall, the State in 1978, questioned about $200,000 in costs. What I can do is give you a collective rundown of what we questioned and the State questioned for both periods of time. And starting with personal travel, we and the State questioned about $15,000 of personal travel, primarily of the primary owner of the facility, which included trips to New York, Vancouver, and Manila in the Philippines.

In addition, we and the State questioned about $43,000 of expenses, including interest on personal loans and purchases, and purchases of bank stock. We also questioned about $30,000 of other nonnursing home business expenses, which included about $13,000 of employee salaries for time spent on other business-related matters.

We also questioned about $85,000 or $86,000 of employee meal, party, and gift expenses, including about $5,000, or $4,500, in liquor expenses, about $2,700 in expenses for flowers, and about $60,000 worth of expenses in the way of gifts and meals for officers and employees of the company.

Chairman HEINZ. Now, what is happening here is that these are being considered legitimate costs of running a nursing home.

Mr. ZIMMERMAN. They were considered by the nursing home as its cost. The State questioned a number of the costs, and they were——

Chairman HEINZ. That amounts to $250,000 being spent on travel to the Philippines, on parties for the personnel, at the same time

as you have documented and the State has documented, I should say, shortages of nursing personnel, is that correct?

Mr. ZIMMERMAN. Yes.

Chairman HEINZ. Now, the GAO has endorsed moving to prospective reimbursement. I think we all, as realists, know that no matter how good a system we devise, there are always going to be those who will find ingenious methods of abusing it.

But, on the other hand, that doesn't remove from us the responsibility of designing the very best possible system we can.

What do you suggest that we do about the fraud and abuse, as you have seen it, from this and other audits under prospective payment? What should we pay most attention to? I note in your testimony on page 7 you said that the Texas ratesetting methodology is insensitive—insensitive is your word—both to the costs associated with the needs of individual patients within the three broad levels of care, and to the mix of individual facilities.

So maybe you can particularly address those two problems.

Mr. ZIMMERMAN. Why don't I have Mr. Iffert respond to that question, based on his broad knowledge of medicaid reimbursement issues.

Mr. IFFERT. Well, when we told you there were some 36 States roughly that had some sort of prospective reimbursement system for nursing homes, that is correct. But those can be divided into, I guess what we call two broad classes. One class would be, consisting of about 15 or 16 States, are like Texas, where it's a class-rated system where you put a large quantity of numbers into a computer and, depending on what methodology is applied, a rate emerges which will be used for that class of care all over the State or an area.

The other type of system is what we call the New York type of system, which a number of other States have used, where it is facility-rated; in other words, what a facility reports in its costs for a prior year is then used, adjusted and used, to pay that particular facility for the following year.

Traditionally, nursing home operators have gotten themselves into difficulty under medicaid by filing false cost reports, claimed reimbursement for payments or expenses not incurred. This was particularly a problem in New York, where, in fact, most of the convictions for nursing home fraud have occurred.

So this really suggests to us that, depending on the type of ratesetting methodology being used, whether you use a facility-rated or a class-rated, your problems with dealing with fraud and the approaches needed to control fraud and abuse may be different.

In a facility-based system, the traditional incentives are still there to overstate or inflate the reported costs, whereas in the class-rated system, the incentives are entirely different, because an individual home or group of homes from a practical standpoint really cannot impact on the rates that are paid, particularly when you have a broad data base like in Texas, with 3,600 or so numbers in various data arrays. We think that in this type of system, a different approach and different controls are probably needed which would focus on the service end of the process, to insure that the program is getting the quality of the services that is being paid for.

Chairman HEINZ. So, in sum, what you are saying is there is going to have to be some kind of a system that insures that the services that would normally be associated with the diagnosis or prescription of care for the particular class of patients is, in fact, delivered, is that in sum what you are telling us?

Mr. IFFERT. Yes; I guess in sum what I am saying is that in some of these class-rated systems, there is really no practical way they can get you going through the front door, so I think you have got to lock the back.

Chairman HEINZ. Well, what we have heard—I am going to yield to Senator Wilson here in just a few seconds—in sum is this: A quarter of a million dollars in costs disallowed. As I understand it, none of it was ever recovered—is that right?

Mr. IFFERT. None of it ever impacted on the rates that were determined.

Chairman HEINZ. The rate was never adjusted.

Mr. IFFERT. No; it shouldn't have been.

Chairman HEINZ. A quarter of a million dollars went for such things as meals for staff at the same time, as Mr. Marks has identified, nutritional intake of patients was being cut back, as the indictments are alleging, that people are dying for, among other things, due to starvation—these costs are being passed on, being charged off, for trips and meals of nursing home staff, not nursing home residents; and that, second, while all of this is going on, this particular nursing home, according to Mr. Marks at any rate, is making a 100-percent return on equity, which means the investors have gotten their entire investment back in 1 year.

You are saying, on top of it, we are going to have to find some new ways of making sure that services, not just the basic services, like making sure that people get enough to eat, but that health care services and nursing services, which are supposed to be there, in fact are there, and it is not going to be all that easy because the State of Texas has found that they were there and you found that they probably weren't.

Do you have any additional advice, Mr. Zimmerman?

Mr. ZIMMERMAN. No; I don't, not with regard to what you said. I do believe, however, that your opening remarks concerning the fact that prospective reimbursement does make new challenges for us in the quality area—and I think that is definitely so—and I think it opens up new doors and new horizons for us, and new endeavors to make sure that the patients are receiving quality care.

Chairman HEINZ. Thank you very much. Senator Wilson.

Senator WILSON. Thank you, Mr. Chairman. Mr. Zimmerman, perhaps you can elaborate for me. As I have indicated, I am new to the work of the committee. It's not quite clear to me why it should make a difference in terms of inspection and steps to assure adequate quality of care whether the payment system is prospective or one of reimbursement.

Looking at your statement on page 9, at the middle of the page, you said: "On the other hand, this same incentive"—the incentive for cost-reduction given by the prospective payment system—"places an increased obligation on the responsible Federal and State agencies to insure themselves that patients are receiving care that meets the applicable standards for quality. One possible ap-

proach," you go on to say, "would be to adopt a system of financial penalties for facilities providing substandard care * * *."

First, maybe you can clear up for me why there is a difference, why you think that the prospective payment system creates an increased obligation, and, second, just specifically how this approach of financial penalties would work. I would think whichever system you employed, you need a system of inspection that allows you to assess a definite penalty, a financial penalty or a licensing penalty.

Mr. ZIMMERMAN. Well, with regard to the first question, Senator, under the retrospective system, providers are usually paid for the costs that they incur, so there is an incentive to incur health care costs with the understanding that you are probably going to be reimbursed for them. Under a prospective system of reimbursement, a limit is established usually, and the incentive shifts. If the limit is, say, $25 a day for health care, for nursing home care, and the provider's costs are exceeding that, there would be a tendency to lower his costs or get his costs below the limit that has been established. In essence, the incentive shifts from providers wanting to provide as much care as they can to maximize their income to a situation where providers may be reluctant to provide care simply because they are going above the limit that they are going to receive in the way of payment.

Concerning the second question, which I believe addressed the issue of some type of penalties for facilities that provide substandard care, as it was pointed out in Mr. Marks' testimony, there were periods of time when the Texas City home received the same reimbursement for care as a hypothetical home would have received, even though there were indications that it was not providing quality care as set forth by the State.

What we have in mind here is similar to mechanisms that have been adopted by a few States that in essence assesses a penalty when the care falls below the level, or the standard, that the State has established, with the idea being that payments should not continue as if the level of care was being received, when in fact it was not.

Senator WILSON. No one can argue with that. My point is simply I would think, regardless whether it is retrospective or prospective, you need a sufficient system of inspection to reveal the quality of care, and then you need penalties.

But I would think that, just as is alleged in this instance, that there was a falsifying of the services and reimbursement for services not actually rendered, that that can be true really in either situation.

Mr. ZIMMERMAN. That is correct. The only point I was trying to make in my statement is that there are new incentives in the game now when you go from a retrospective system to a prospective system from the standpoint that the incentives now are to spend less rather than to spend more, and to the extent that spending moneys to provide care enhances the quality of care, then there is the possibility that quality care may not be received or be received in a less-than-desirable amount.

Senator WILSON. Well, given that concern—and I understand it—do you think that there is really a difference, though, in terms of what your costs will be for an adequate system of inspection? What

you are saying is that there is a temptation on the part of the provider to skimp because he won't be fully reimbursed, or may not be.

Mr. ZIMMERMAN. That's correct.

Senator WILSON. That because of that temptation there may be need for greater efforts to keep him honest.

Mr. ZIMMERMAN. Greater efforts to keep him honest and greater efforts to make sure that the beneficiaries are receiving the appropriate level of care.

Senator WILSON. The thing I am having difficulty with is it would seem to me that regardless of which system you used, you have got to have a system that gives you the assurance that people are receiving quality care and that there is not, in that connection, fraud being committed by people being paid as providers for services they are not rendering, and I wouldn't think that the mechanism would be different, regardless of whether it is prospective or retrospective reimbursement.

Mr. ZIMMERMAN. Whatever mechanism that would be used to assess quality would obviously have to look at what kind of care the patient is receiving and equate that to what the standards require.

So in that sense of the word there probably wouldn't be a difference.

I think all we are trying to highlight in the statement here is that, again with the increased emphasis on prospective reimbursement and the inclination I believe that would take place for providers to try to keep their costs below the payment rate, there may be a tendency on the part of those providers to skimp on the patient care, which is usually the biggest part of nursing home costs.

Senator WILSON. GAO is recommending the prospective system, did I understand that?

Mr. ZIMMERMAN. Well, we are in support of the concept of prospective reimbursement, not just in nursing homes but across the whole industry.

Senator WILSON. To all providers.

Mr. ZIMMERMAN. Basically.

Senator WILSON. So what you are saying is, while you think that's a good idea, it may involve some heavier burden and some increased cost of inspection.

Mr. ZIMMERMAN. That's correct.

Senator WILSON. Is there any way that you can quantify that?

Mr. ZIMMERMAN. I can't, but maybe Mr. Iffert has some insight into that.

Mr. IFFERT. Well, I think it would help to understand that the inspections we are talking about, the annual surveys that the States make of facilities, really don't measure quality of care as you and I would talk about it and Mr. Marks was talking about it. It measures the ability of the facility to deliver quality care. It focuses on things like fire safety, the number of nurses there. It is facility specific; it is really not patient specific.

Now, there is another mechanism in the medicaid program required by 1903(g), which requires each State to have what they call a utilization control program, where each of the nursing home patients is examined annually by professionals, either employed by

the State or under contract to the State through medical societies, or PSRO's, or whatever. And that really is your quality control mechanism which is patient oriented, seeing that the patients, the ones that are still there, were being provided care consistent with the plan of care as required for each patient upon admission.

Quite frankly, we did not examine those reports in connection with our review of Texas, so I can't really respond as to what went wrong. But I am pointing out that there is a mechanism in the Federal statute which is patient oriented. And maybe that needs to be beefed up a little bit.

Senator WILSON. Do the States, in your experience, go beyond what is required in the Federal regulations with respect to either facility or patient standards?

Mr. IFFERT. Well, on the survey, the procedures are highly standardized, because—the standards for SNF's are the same with respect to medicare and medicaid—so the survey requirements are highly standardized.

On the utilization control mechanism that I was talking about, there is more flexibility for the States as to how they do it. If they don't do it at every home, then there are more or less financial penalties that the Federal Government imposes on the State for failure to comply with that provision.

Senator WILSON. What I am really driving at, in line with the desire to see an improved system of monitoring, I am wondering whether or not there is a uniformity, as between the States, in terms of the procedures that they employ?

Mr. IFFERT. On the federally mandated inspections, I would say "Yes." On the inspection function, I would say "Yes."

Senator WILSON. How about the overall question of determining quality of care?

Mr. IFFERT. Then I would have to say simply, "No."

Senator WILSON. Have you addressed that with any specific recommendations for change?

Mr. IFFERT. I think the best way to answer that is in the past we have compared the findings, in ICF's, that a survey inspector come up with the findings that the team that was involved in evaluating the needs of individual patients came up with that second part of the system, and there were wide discrepancies in the findings of both, so there were definitely an incompatibility there, and we made some recommendations that were aimed at trying to eliminate that incompatibility. I don't know how successful we were.

Senator WILSON. Thank you.

Chairman HEINZ. Thank you. Senator Melcher.

Senator MELCHER. Is it fair to say, Mr. Zimmerman, that the General Accounting Office recommendation for prospective payment is made out of a combination of improving the mechanics of payment and also to bring about circumstances where costs are held down?

Mr. ZIMMERMAN. I think, generally speaking, it has been suggested that the prospective payment systems do accomplish both.

Senator MELCHER. Well, it's been suggested, but the General Accounting Office recommendation to the Congress is to make sure that that is implemented, is in fact good, that you feel confident to recommend it to Congress without just saying there is merit to it;

you say, yes, we find enough merit in it to recommend to the Congress to make sure that it is done that way.

Mr. ZIMMERMAN. I am not sure that we made a recommendation and based it on the specific points you have raised. However, let me again refer the matter to Mr. Iffert and maybe he can recall the basis for the position we took on prospective reimbursement.

Mr. IFFERT. Well, I think it was essentially supporting the idea of moving away from the retrospective system that has been blamed, I guess, for most of the ills in the health care business in terms of rising costs, and moving to some sort of prospective system which would attain the incentives of holding down costs.

But we have never come up with a specific formula or a specific methodology for doing that.

Senator MELCHER. You are not at that point.

Mr. IFFERT. No, sir.

Senator MELCHER. I want to pursue that a little bit. Have you reached the conclusion that there should he a national standard price established for each diagnostic-related group?

Mr. ZIMMERMAN. I would say that we have not. As Mr. Iffert indicated to you, we have not taken a position on a proposal for prospective reimbursement.

Senator MELCHER. Because your work is incomplete?

Mr. ZIMMERMAN. Well, to be perfectly frank with you, we are really waiting for the administration to come forward with its proposal before we will comment on it. I understand they have submitted a report; we are waiting for the actual proposal. At that point in time I am quite sure the Office will offer comments on what we think about it.

Senator MELCHER. Well, maybe we should have been ahead of that and asked the General Accounting Office to make such an evaluation without having to wait on the administration. But, be that as it may, as I understand it, there will be a certain number of diagnostic-related groups and a prospective payment will be made based on a national payment. That has a certain amount of attraction to me, and I would like to be advised as quickly as possible how the General Accounting Office finds the specific proposals.

Mr. ZIMMERMAN. Senator, we would be more than glad to convey that information to you after we get a chance to look at the proposal.

Senator MELCHER. All right, thank you very much. Thank you, Mr. Chairman.

Chairman HEINZ. Mr. Zimmerman, thank you very much. We appreciate your very helpful testimony.

[Subsequent to the hearing, Mr. Zimmerman submitted the following material related to prospective reimbursement:]

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-207300

MAY 10, 1982

The Honorable Bob Packwood
United States Senate

Dear Senator Packwood:

Subject: Information on Prospective Reimbursement Systems (GAO/HRD-82-73)

Your January 6, 1982, letter posed three questions relative to the use of a prospective reimbursement system under Medicare. Specifically: What savings could be achieved? Which Government procurement policies would be appropriate under such a system? And how do various procurement policies handle payments for profit and property-related costs? Briefly stated, our responses to these questions are:

--Prospective reimbursement is more a concept than a system. A particular set of rules to pay providers prospectively could be designed to achieve almost any level of program savings desired. Of course, there is a point when a reduction in reimbursement could adversely affect access to care and/or quality of care. Also, if the prospective reimbursement does not apply to all payers, a facility can have an incentive to shift costs to non-covered payers.

--Currently, Medicare reimbursements are based on principles very similar to those used by the Government to negotiate the purchase of other goods and services. Medicare would need to continue using these or similar principles under a prospective reimbursement system if such a system were to have any assurance that reasonable payments are made.

--In general, Government procurement policies recognize property-related costs as part of the cost of doing business and recognize it through depreciation payments. Whether or not profit is specifically addressed normally depends on the type of contract. Firm fixed price contracts resulting from advertised procurement actions normally would not specifically address profits while negotiated cost-plus-a-fixed-fee contracts would.

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Our detailed responses to your questions follow. Our analysis was based primarily on a review of existing Department of Health and Human Services (HHS) and GAO studies, Government contract procurement policies, and Medicare reimbursement regulations and guidelines. Because Medicaid is the primary payer of nursing homes, we used State reimbursement systems as examples in the report. Also, we held discussions with officials of the administering agency within HHS--the Health Care Financing Administration (HCFA). As instructed by your office, our response is limited to reimbursement for hospitals and nursing homes. Our work was performed in accordance with the Comptroller General's current standards for audit of governmental organizations, programs, activities, and functions.

HOW MUCH CAN A PROSPECTIVE REIMBURSEMENT SYSTEM SAVE?

Medicare currently pays most hospitals and nursing homes on a retrospective cost basis; that is, at the end of a period (usually a year) a facility's actual reasonable and allowable costs of providing care to Medicare patients are determined and payments made during the year are adjusted to equal that amount. Under a prospective reimbursement system, Medicare would determine before the services are provided the amount or rate it would pay a facility to provide care.

Under prospective reimbursement systems, facilities normally retain as profit all or part of payments received which exceed costs and normally suffer a loss if costs exceed payments. In theory, a prospective system provides incentives to facilities to be efficient because (1) they know in advance how much they will be paid and that they will suffer a loss if costs are higher and (2) they can make a profit if their costs are below the amount of payments they will receive. Medicare has participated in several localities' prospective reimbursement systems on an experimental basis. The results of these experiments continue to be evaluated.

A prospective system can be designed to achieve almost any level of program savings desired by selecting the appropriate set of rules. However, there is a point when a reduction in reimbursement could adversely affect access to and/or quality of care for beneficiaries. Also, if the prospective reimbursement does not apply to all payers, a facility can have an incentive to shift costs to non-covered payers.

A number of States have established prospective reimbursement systems for hospitals. In establishing these systems, the specific techniques used vary but can be classified broadly as budget-review, formula, and negotiation.

--Under the budget-review approach, the reviewing agency evaluates the projected annual budget and rate schedules of each hospital and sets or approves the budget and rates using the criteria established by the reviewing agency.

--The formula method uses a formula or group of formulas to determine the appropriate reimbursement rate for a facility. Formulas include those using averages, indices, or projections of established cost trends. New prospective rates or rate changes are usually computed annually and may be derived by adding a standard percentage to an institution's base rate or by relating the rates to one or more indices that reflect various rates of cost increase in the general economy.

--The negotiation method usually begins with a budget-review or a formula-derived rate, followed by negotiations between the hospital and the ratesetting authority.

Many States pay nursing homes a fixed per diem rate established on a prospective basis for the care of Medicaid patients. States use various techniques, some of which are very complex, to develop the rates of payment. Some States have established uniform rates by type of facility or level of care while others have established rates on the basis of additional characteristics, such as nursing home size and location. Examples of the techniques used are as follows:

--In Texas, the rates by type of facility (SNF--skilled nursing facility, ICF--intermediate care facility) are developed based on the allowable costs for patient care, dietary, facility, and administration. The State arrays the patient care costs by type of facility and sets the costs of the facility at the 60th percentile as the patient care subrate. Using the same procedure, separate subrates applicable to all types of facilities are developed for dietary, facility, and administrative costs. The sum of the four subrates becomes the statewide rate for each type of facility.

--California establishes rates for SNFs based on the 50th percentile of the costs of facilities arrayed by several bed size groups and regions within the State. ICFs receive 80.5 percent of the SNF rate for the applicable bed size group. Special amounts are added to the rates for facilities providing special services to the mentally disordered and separate rates are established for the developmentally disabled.

--In Minnesota, prospective payment is based on each facility's cost experience plus its projected cost increases. The maximum amount payable is limited to 125 percent of the average costs of facilities providing the same level of care, with the same type of ownership, and within the same region of the State.

Setting a rate in advance (prospective reimbursement) theoretically provides a health care provider the incentives to better plan and manage because it knows the amount it will receive and that it will suffer a loss if it exceeds that amount. Conversely, under a retrospective system, planning and management is said to be less important because final payment reflects the actual costs incurred with little consideration of whether the costs were incurred economically or efficiently. However, Medicare's present retrospective system does contain some features which should provide an incentive to be efficient.

Section 223 of the Social Security Amendments of 1972 authorizes the Secretary of HHS to prospectively establish limits

> "* * * on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title."

Using this authority, the Secretary has established prospective maximum amounts Medicare will pay for hospital per diem costs, home health visits, and skilled nursing home care.

Regarding the certainty of payment amount issue, retrospective adjustments to rates established under a prospective reimbursement system have taken place. For example, in Maryland and Washington, periodic adjustments are made if projected hospital revenues and expenses substantially increase or decrease beyond what was projected. Also, in New York State, where a prospective ratesetting system has been implemented for a private insurer and Medicaid:

> "the typical hospital experienced approximately seven rate changes in 1974, six rate changes in 1975, and five rate changes in 1978 for its inpatient care activities. Thus, it appears

that the implied benefits of prospective reimbursement were eroded by the frequency of the rate changes." 1/

Several studies have been made of prospective reimbursement systems and all have discussed differences in how these systems are implemented. In August 1980, HCFA's Office of Research, Demonstrations, and Statistics published a report entitled "The National Hospital Rate-Setting Study: A Comparative Review of Nine Prospective Rate-Setting Programs." The report pointed out that prospective reimbursement systems can and do vary greatly from State to State. Also, the report stated that:

"Rising Medicaid budgets and insurance premiums were the two primary reasons for adoption. Secondary objectives for adoption were to reduce payer cross-subsidization and to demonstrate a viable, decentralized, nonfederal approach to hospital regulation.

"The greater the perceived financial crisis in Medicaid budgets and insurance premiums, the greater the authority vested in the rate-setting body.

"The political orientation of states toward government regulation influenced the type of program adopted: the more laissez-faire, antiregulation the state, the more decentralized and voluntary the approach."

In a September 1980 report to the Congress, we made a comparison of States using retrospective reimbursement systems with those States using various types of prospective systems. The report is entitled "Rising Hospital Costs Can Be Restrained by Regulating Payments and Improving Management" (HRD-80-72, Sept. 19, 1980). For the years 1975-77, the average expenditures per case for all community hospitals increased 14.9 percent annually; for States having retrospective systems, the annual rate of increase was 17.9 percent, and for States using a prospective system, the expenditures increased on the average 13.9 percent per year.

1/Ruchlin, Hirsch S. and Rosen, Harry M. "The Process of Hospital Rate Regulation: The New York Experience," Inquiry, Vol. 18, No. 1, Spring 1981.

We concluded that while the hospital expenses per case continued to grow in all States in recent years, the rate of increase had generally been lower in States with prospective ratesetting programs. This lower growth rate suggested that the ratesetting programs had successfully diminished the cost escalation spiral. In some States, the rates of increase in hospital costs had dropped dramatically. This was especially true for States with mandatory-regulatory-type 1/ prospective ratesetting programs. Thus, it appeared that the mandatory-regulatory-type program offered the greatest potential for controlling hospital costs.

A more recent study published in the "Health Care Financing Review/Winter 1981" also shows differences in prospective reimbursement systems and that they have had some success in reducing hospital expenditures. The study--entitled "An Analysis of the Effects of Prospective Reimbursement Programs on Hospital Expenditures"--concludes that

> "The statistical evidence indicates that some PR [prospective reimbursement] programs have been successful in reducing hospital expenditures per patient day, per admission, and per capita. Eight programs--in Arizona, Connecticut, Maryland, Massachusetts, Minnesota, New Jersey, New York, and Rhode Island--have reduced the rate of increase in expenses by 2 percentage points or more per year and, in some cases, by as much as 4 to 6 percentage points. There are indications, although less strong, that PR programs also reduced expenses in Indiana, Kentucky, Washington, western Pennsylvania, and Wisconsin. There are no indications of cost reductions for programs in Colorado and Nebraska.
>
> "An analysis of the relative effectiveness of the various programs suggests that mandatory programs have a significantly higher probability of influencing hospital behavior than do voluntary programs. Some voluntary programs, however, are shown to be effective."

1/Mandatory-regulatory indicates that the program was created to comply with the requirements of a State governmental act or resolution either distinct from or as an addition to an existing law. Such programs have the authority to determine or alter rates, charges, costs, or revenue of a health care institution.

The study cautioned, however, that only part of the evidence that deals with the effects of prospective reimbursement has been examined and that the results must be considered preliminary.

With respect to nursing homes, in October 1981, the Office of Research, Demonstrations, and Statistics published a report on prospective reimbursement entitled "An Overview of Medicaid Nursing Home Reimbursement in Seven States." The report examines the experience of seven States using prospective reimbursement and while it does not estimate any savings, the report again provides considerable insight to the widely varying ways that a prospective reimbursement system can be implemented. Also, among other things, the study concluded:

> "* * * although reimbursement procedures are technical in nature and replete with specific accounting procedures and reports, they are, in fact, the end result of political decisions made by the state with or without the involvement of the industry.
> * * * designating a system prospective or retrospective provides not only incomplete but often misleading descriptions of payment system. Both a facility independent system without adjustments (e.g., a flat rate) and a facility specific system with a host of pass throughs, exceptions and adjustments can be termed prospective although the latter in fact bears closer resemblance to a retrospective payment method because it makes such large allowances for costs incurred after the fact."

WHICH GOVERNMENT PROCUREMENT POLICIES COULD BE APPLIED TO MEDICARE?

Although Medicare reimbursements are based on principles very similar to those used by the Government to negotiate the purchase of other goods and services, they differ in some cases because of program differences. Medicare would need to continue using similar principles under a prospective reimbursement system if such a system were to have any assurance that reasonable payments are made. This is because reasonable prospective rates can only be set based on a knowledge of current reasonable costs of efficient and economic providers. Therefore, a set of rules establishing what constitutes reasonable costs would still be necessary.

The Federal Procurement Regulations (FPR) are issued by the General Services Administration and are contained in chapter 1 of subtitle A of title 41 of the Code of Federal Regulations

(CFR)--Public Contracts and Property Management. Chapters 2 through 49 of subtitle A contain procurement regulations issued by individual government agencies which implement and supplement the FPR. Chapter 3 contains these for HHS programs.

The Medicare law states that providers of health services 1/ shall be reimbursed "reasonable costs." The implementing regulations are contained in 42 CFR 405 subpart D--Principles of Reimbursement for Provider Costs and for Services by Hospital-Based Physicians. Additional program guidance is provided in Medicare's Provider Reimbursement Manual. As a condition of participation in the Medicare program, providers of health services agree to abide by applicable Medicare laws and regulations. This "provider agreement" in effect could be viewed as a "contract" between the Medicare program and health care providers.

A general comparison of the FPR with Medicare's reimbursement regulations shows a great deal of similarity. For example, both provide that cost be reasonable and related to the activity at hand and both allow certain costs while disallowing others. Some differences exist between the two. The FPR, for example, do not allow interest or bad debts' expense. Conversely, Medicare allows interest expense, and allows bad debts to the extent that they result from Medicare patients' failure to pay deductible and coinsurance amounts.

The similarities and differences between Medicare and the FPR with respect to the recognition of profit and depreciation are discussed below.

HOW ARE PROFIT AND PROPERTY-RELATED COSTS HANDLED UNDER VARIOUS PROCUREMENT POLICIES?

Generally, both Government procurement policies and Medicare allow profit for proprietary organizations. Also, both recognize property-related costs as part of the cost of doing business and allow reimbursement for depreciation.

Profit or return on owner's equity

Under Medicare, for-profit health care providers are allowed a return on owner's equity. Equity return is computed at 1-1/2 times the average rate of interest on obligations held by

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1/Providers of service are defined as consisting of hospitals, skilled nursing facilities, and home health agencies.

Medicare's Hospital Insurance Trust Fund. This rate is applied to the provider's equity capital which generally consists of the provider's investment in plant, property, and equipment less depreciation, and working capital maintained for the operation of patient care activities. The current rate used in the equity capital computation is about 20 percent. Also, in recent years, some nonprofit hospitals have attempted to obtain reimbursement for a return on equity; however, they have not been successful. Several cases are currently being appealed in the courts on this issue.

The FPR allow profit organizations a profit on negotiated fixed-price and cost-reimbursement contracts. The amount of the profit allowed is largely left to the discretion of the contracting officer; however, he/she is required to consider such factors as contractor efficiency, difficulty and nature of the work, and total investment required.

Depreciation

Under the FPR, depreciation is generally based on the acquisition cost of the asset or the fair market value of a donated asset at the time of the donation. Commercial firms may use any depreciation method that is acceptable for Federal income tax purposes.

The Medicare regulations provide that the asset value be based on the historical or acquisition cost, except that historical cost cannot exceed (1) current reproduction cost less straight-line depreciation or (2) fair market value at the time of purchase. 1/ The regulations generally provide for using only the straight-line method of depreciation. Assets purchased before August 1, 1970, may be depreciated on an accelerated basis.

Accelerated depreciation for assets acquired on or after August 1, 1970, may be authorized only where the cash flow from depreciation on the provider's total assets does not supply funds sufficient to meet the amortization of a reasonable amount of principal on debts related to the total depreciable assets.

A major difference between the FPR and the Medicare regulations for determining the basis of depreciation is that, while

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1/Providers can also depreciate assets donated to them. Similar rules apply to the valuation of such assets for depreciation purposes.

the FPR use acquisition costs, Medicare uses historical cost limited to current reproduction cost less straight-line depreciation or fair market value at the time of purchase. Before 1970 the Medicare basis for depreciation was the lower of (1) cost or (2) fair market value at the time of purchase. The regulations were revised, however, to add current reproduction cost less straight-line depreciation at the time of purchase as a criterion for limiting the basis for computing future depreciation. This criterion was established in recognition of the higher program costs that resulted when facilities were sold for prices substantially exceeding the selling providers' costs.

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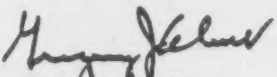
On February 2, 1982, before the Subcommittee on Health, House Committee on Ways and Means, HCFA's Associate Administrator for Policy summarized HCFA's views on the shortcomings of retrospective reimbursement and expressed the hope that a viable prospective system could be developed. She stated:

> "This Administration is philosophically opposed to retrospective cost reimbursement. The present system of cost reimbursement of hospitals and skilled nursing facilities for services provided to Medicare beneficiaries stifles competition, carries with it the need for extensive Federal regulation, and is a major factor in the rapid growth of health care costs. In large part, the system of retrospective cost reimbursement has been one of the major contributors to the high rate of inflation.
>
> "We are working to design a system of prospective reimbursement, but this is a difficult and complicated process and it will take time to develop. We are working with a variety of both internal and external groups to develop new approaches to reimbursement, and we would certainly welcome this Committee's advice and suggestions."

Along these lines, the Administrator of HCFA received a report from a Task Force she established to study various options with respect to establishing a prospective reimbursement system for Medicare's hospital and skilled nursing benefit. The options presented are now being reviewed by the Administrator.

As requested by your office, we did not obtain comments from HHS on this report. As agreed with your office, we plan no further distribution of this report until 30 days from its issue date. At that time, we will send copies to interested parties and make copies available to others upon request.

Sincerely yours,



Gregory J. Ahart
Director

Chairman HEINZ. If Senator Bradley were here, he would be pleased to know that our next witnesses are from New Jersey. Marc Allen and Dennis Duffy.

STATEMENTS OF B. MARC ALLEN, EXECUTIVE DIRECTOR, ESSEX PHYSICIANS REVIEW ORGANIZATION, INC., SOUTH ORANGE, N.J.; AND DENNIS J. DUFFY, EXECUTIVE DIRECTOR, SUBURBAN MEDICAL REVIEW ASSOCIATION, INC., KENILWORTH, N.J.

Mr. ALLEN. Thank you, Mr. Chairman. My name is Marc Allen, I am the executive director of the Essex Physicians Review Organization in South Orange, N.J. My associate is Dennis Duffy, executive director of Suburban Medical Review, located in Kenilworth, N.J.

The Essex Physicians Review Organization and the Suburban Medical Review Association are federally designated professional standards review organizations under Public Law 92-603, and are designated as utilization review organizations under chapter 83 of Public Law 78 of the statutes of the State of New Jersey. It is our responsibility to review medicare inpatients under the Federal statute, and all other patients entering New Jersey hospitals under State statutes, to determine appropriateness of care, lengths of stay, services rendered, with emphasis on quality of care, and to determine whether the hospital level of care is the most appropriate and economic setting.

The two PSRO's we represent have over 2,000 physician members representing 70 percent of the actively practicing M.D.'s and D.O.'s in our service area. Our counties comprise a mix of urban and suburban populations with many cities and towns. There are over 1½ million people served, 27 hospitals, and approximately 175,000 medicare eligibles in the two-county area.

We have been reviewing medicare patients since 1976, and, as of this time, have reviewed approximately one-half million discharges of same, and 1 million patients in total. Statewide, throughout New Jersey, there are eight PSRO's reviewing all patients in approximately 100 hospitals. The combined program is now reviewing 1.2 million cases annually and has physician membership and involvement of approximately 6,500.

With the passage of the Tax Equity and Fiscal Responsibility Act of 1982, including the peer review improvement section, the Essex Physicians Review and the Suburban Medical Review are preparing for the implementation of that program by pursuing plans to merge with one or more other local PSRO's into a more cost-efficient administrative structure for review. We anticipate and hope to save the Health Care Finance Administration an additional 25 percent of our administrative costs and overhead of our grant through this consolidation.

The New Jersey PSRO's expanded their role beyond the traditional review of medicare and medicaid in 1981, with the implementation of the New Jersey prospective reimbursement by the case regulations. That regulation included a requirement for utilization review of all patients in New Jersey hospitals by an organization that looks very much like a PSRO, or a peer review organization, a PRO. In New Jersey, there is another acronym—they call

us utilization review organizations, and we have been reviewing patients of all pay sources in all hospitals in New Jersey as they come into the reimbursement mechanism.

It is well known that the prospective by-the-case reimbursement system envisioned by Health Care Financing Administration changes incentives to hospitals and physicians with regard to the delivery of health care, as opposed to the reasonable-cost reimbursement system now in effect. It will no longer be in the best interest of the hospital to render more services so as to receive more reimbursement. On the contrary, the incentive is for the hospital to restrict services to a minimum because it will receive the price per case regardless of the length of stay or the resources consumed.

Obviously, it is the intent of HCFA to reduce hospital expenditures within the medicare program. The trick is, however, to make sure these services are reduced only to the appropriate minimum and not below that line. Only local physician-directed peer review can assure that that line will not be crossed.

We, as experts in utilization review and quality assurance, are concerned that a climate will be created in which three situations might occur. The first is the possibility that questionable or unnecessary admissions will be encouraged by hospitals or physicians in order to receive the price per case available for any patient admitted within a given DRG. The second is the reduction or deprivation of quality of care caused by the lessening of needed resource consumption or hospital ancillary services, as we call them, in order to maximize profit-per-case reimbursement. The third fear is the manipulation of diagnosis coding and DRG assignment so as to maximize reimbursement beyond what might be expected. You may have heard of this phenomenon in the literature—it is called "DRG creep."

In New Jersey, we have already begun to address these changing incentives and influences through our concurrent physician-directed utilization review program. Because of the quality, the integrity, and the honesty of the review process by local physicians, these three fears do not appear to be coming to pass. We are afraid to consider what the situation might be without the mandated peer review.

Our system utilizes nurse review coordinators and physician review advisers who are basically volunteers from the active M.D.'s and D.O.'s in the community who review on a daily basis the medicare cases while they are in the hospital.

The review process includes review for the necessity of admission and continued stay as well as the review for the use of services, such hospital ancillaries as laboratory, X-ray, physical therapy, inhalation therapy, surgical procedures, and others, with special attention to over- and underutilization of those services.

This combined utilization and quality assessment approach clearly identifies unnecessary services and poor quality of care, and gives opportunity for the immediate correction of same.

It is not uncommon, through the process described, to identify patterns, for example, of unnecessary surgery, such as many D&C's found to be performed and later determined to be unnecessary and of marginal value, and these have been stopped. In fact, our physician reviewers have on occasion come to be considered consultants

by attending physicians who frequently seek input on the management of their cases.

My colleague will now review various specifics of the process and will cite examples of our quality-assurance activities.

Chairman HEINZ. Mr. Duffy.

Mr. DUFFY. I would like to describe briefly our review system and demonstrate how we assess the quality of care.

As soon as a patient is admitted to a hospital, one of our nurse coordinators reviews the case, using criteria established by local physicians. If the admission is questionable, the coordinator refers it to a physician adviser who will review for necessity and quality of care. The physician can then either approve it for admission and continued stay in the hospital or deny benefits after discussing the case with the attending physician.

This activity has both a direct and sentinel effect on the appropriateness and quality of care rendered at the given institution. Some critics say this peer interaction could be replaced by fiscal-intermediary computer analysis. This, simply, is not the case. This instant concurrent peer review is more palatable to the medicare beneficiaries due solely to its timeliness, and the attending physicians appreciate the direct peer contact instead of computer and clerical analysis.

Pertinent to the foregoing, both EPRO and the SMRA have just demonstrated in 1981–82 comparisons, reductions in admissions and in their rate of increase for both the medicare and medicaid programs.

Under New Jersey's DRG payment system, there has been a fear of deprivation of the quality of medical care due to the new reimbursement incentives. Our review organizations have developed three types of quality-of-care review.

The first is formal quality review studies, performed by physician specialty committees on topics which are either known problems or suspected problems. An example would be a study we did on bilateral cataract surgery. The ophthalmologists on the committee set the criteria and, after detailed review of over 700 charts during the study and restudy, found one physician who was performing simultaneous bilateral cataract surgery, which presents high risk of infection and blindness to both eyes. The committee dealt with the physician involved and he has ceased performing this type of procedure.

Since no one died or became dangerously ill due to this procedure, computerized review would not have picked up the problem.

Our organizations also perform special quality studies, which are conducted on specific topics for a limited period of time. An example is an in-depth analysis of the increasing postoperative respiratory complication rate in cholecystectomy patients, which was studied by our physicians and nurses during 1982. The study revealed a 12-percent documented rate of postoperative complications such as pneumonia occurring in high-risk patients. Corrective action included continuing education programs for physicians to instruct them in proper identification of high-risk patients, performance of pre-op pulmonary evaluation and prompt delivery of respiratory therapy when clinically indicated. Followup monitoring will occur

during early 1983 to ascertain the effectiveness of programs established.

We also conduct concurrent quality assurance studies. Recently we reviewed cholecystectomy, abdominal and vaginal hysterectomy, and permanent pacemaker insertion.

Overall the studies revealed compliance with quality and necessity criteria, but some problems were revealed at two hospitals and these issues will be addressed during 1983.

Another fear of the DRG payment system is "DRG creep," or miscoding and manipulation of the diagnosis and/or the DRG. We deal with this situation by review and validation of DRG assignment during hospital monitoring visits and DRG appeal hearings. An extreme example is the case of a hospital coding DRG 121, acute myocardial infarction, which would reimburse the hospital the amount of $6,672.50. Our followup validation resulted in a change to DRG 132, congestive heart failure, which carries a $2,363 price tag, a difference of $4,300. The key to this program is physician chart review, and then the remapping of the DRG based on the physician review.

It is clear through the testimony and supporting documentation we are leaving you that PSRO's or PRO's have developed the necessary expertise and programs to address the proposed medicare payment system.[1]

An anecdote that might crystallize the need for peer review is the case reported in this past Saturday's issue of the New York Times. It described a concern about the high death rate of heart patients who underwent surgery at an Air Force hospital in Texas. Federal law precludes PSRO's from reviewing in military hospitals. The report stated that cardiologists at the hospital were concerned over a particular physician's performance, and they maintained records showing that 44 percent of his patients died from 1974 to 1977, as compared with a 9-percent rate for the other physicians. It is not inconceivable to assume that PSRO concurrent review and quality assurance would have identified and validated the problem and prevented a recurrence in a timely fashion.

Leaving you with that note in mind, we thank you for the opportunity to appear before your committee, and we will be glad to answer some questions.

Chairman HEINZ. Mr. Allen, Mr. Duffy, thank you very much.

We are going to hear from Carolyne Davis, the administrator of HCFA, in a few minutes. She was kind enough to give us her prepared remarks yesterday. I have had a chance to review them.

In those remarks, she, as I understand them, maintains that under a prospective system that quality can be maintained by improved hospital conditions of participation, first, and, second, increased admission monitoring by HCFA staff and fiscal intermediaries.

You have really testified to the contrary, that it is going to take PSRO's, which the administration, of course, in the budget they sent down earlier this week, has proposed to zero out of the Federal budget.

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[1] See appendix, item 1, page 105.

Why, in your own words, do you believe Dr. Davis is mistaken and is mistaking the ability of HCFA, of computers, and of improved conditions of hospital participation, to address the issues of quality assurance?

Mr. DUFFY. One thing we have discovered over the years is that you can't wait for an admission pattern to develop. You need data available to you immediately. I am not quite sure, but I imagine HCFA's data will be basically the same what they have now, which takes quite some time to collect and process through.

In addition to the data lag problem, I think the intermediaries would need quite a bit of funding to begin to perform this task, because at least the one in our State is completely underfunded for the tasks they are presently performing.

Put all that aside, the important thing is you have got to have physicians looking at other physicians. Everything we heard today about the care in that nursing home—there have got to be health care professionals from the outside looking into a health care facility. It works.

Mr. ALLEN. HCFA, or its predecessor, and its fiscal intermediary system were responsible for review from the enactment of medicare in 1966 until Senator Bennett's amendment implementing medicare PSRO in 1972. The Senate itself judged fiscal intermediary review to have failed and looked for a local physician-directed program.

It failed in the past because funding was inadequate, data was poor or questionable, and the relationships that type of audit created with the providers and the beneficiaries didn't work. It created problems. There was retrospective review, retrospective denial.

The fact that PSRO programs were implemented, that physicians have their cases discussed on a concurrent basis, that patients are aware on a concurrent basis whether or not their care is to be reimbursed, et cetera, points to the success of the peer review, concurrent peer review program as opposed to that.

Chairman HEINZ. What about the idea of linking this function to the fiscal intermediary?

Mr. DUFFY. The review function?

Chairman HEINZ. Peer review, yes—or review.

Mr. DUFFY. Well, it would get back to unfortunately what Marc just described, the old situation, which at that time someone thought was ineffective. That is why they created PSRO's.

Chairman HEINZ. Thinking now about a prospective system as opposed to the previous system, is there any difference here? Do you think the quality assessment incentives for the fiscal intermediary under prospective reimbursement are stronger or weaker?

Mr. ALLEN. Well, if I might, I am not sure that the incentives change to the fiscal intermediary one way or the other. I think the issue becomes the ability to implement the system that works.

Now, it seems to us that everybody has pretty much decided that concurrent and peer review is preferable; it is simply a matter as to who should do it and how it should be funded.

If the function were turned over to the fiscal intermediaries, they would have to replicate the system we have put into place.

The credibility of their system would be questionable insofar as the physicians doing the review would then become consultants to the insurance company or employees of the insurance company, and this is something that organized medicine and physicians in general have opposed.

Chairman HEINZ. Very well, one last question before I yield to Senator Wilson. We did an investigation of pacemakers in this committee about 4 or 5 months ago. What we discovered in the committee was, of the $2 billion annually which medicare reimburses providers for pacemakers, that perhaps as much as one-half of that amount, $1 billion a year out of a $60 or $65 billion medicare program is spent unnecessarily due to improper utilization, overpayments, a variety of very wasteful, and on occasion, dangerous practices.

What does New Jersey reimburse for this procedure and how does the DRG assist in the necessity or appropriateness of diagnosis here?

Mr. DUFFY. I have no idea what they would be reimbursed for that particular procedure.

Chairman HEINZ. We would be interested in following up with you on that to see if you are the exception to what looked like a pretty sloppy rule.

Mr. DUFFY. There is the view that there is unnecessary use of at least temporary pacemakers in emergency rooms and things like that. That was the study we were referring to, and when we complete it we will be glad to send it to you.

Chairman HEINZ. When do you anticipate that study will be completed?

Mr. ALLEN. Hopefully before the summer. It's a restudy of the initial study. We found the data that we were looking for; now we are going to see what the impact was.

Chairman HEINZ. All right, I don't think there are any other questions. Thank you both very much, you have been extremely helpful.

Our next witness is Carolyne Davis, the Administrator of the Health Care Financing Administration.

Carolyne, thank you very much for your patience. Our hearing is running, as you know, behind schedule, and I apologize for any inconvenience it may have occasioned.

Please proceed. If you wouldn't mind, I think we would benefit from you introducing your associates at the table.

STATEMENT OF DR. CAROLYNE K. DAVIS, WASHINGTON, D.C., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES; ACCOMPANIED BY DANIEL BOURQUE, DEPUTY ADMINISTRATOR; MARTIN KAPPERT, DEPUTY ASSOCIATE ADMINISTRATOR FOR OPERATIONS; AND PATRICE FEINSTEIN, ASSOCIATE ADMINISTRATOR FOR POLICY

Dr. DAVIS. Certainly, I would be happy to. I am very pleased that you have asked us to be here today to reflect on our prospective payment system under medicare for hospitals, particularly to reflect upon how it impacts on the quality assurance aspects.

On my left is Patrice Feinstein, who is Associate Administrator for Policy; on my right is the Deputy Administrator, Daniel Bourque; and to his right is our Deputy Associate Administrator for Operations, Martin Kappert.

Let me begin by trying to go quickly over what our prospective proposal is.

First of all, it is a proposal that is developed for medicare only, and it is for inpatient hospital services. We have developed it with a diagnosis-related group, which means that we will have specific payment rates for each of 467 diagnostically related groups. These groups will be adjusted by a regional wage factor.

Now, what this really means is that any hospital within, let's say, the city of Baltimore, would be getting the same rate, the same basic rate, for that DRG, because they are in the same regional wage area.

These would be adjusted by an annual update, and we would take into consideration inflation within the hospital market basket, technology development, and productivity.

For a few variables, we would allow passthroughs. One would be capital, and the other would be medical education.

Chairman HEINZ. That would be based on more or less the same method we have now of reasonable costs.

Dr. DAVIS. We didn't want to put those into our diagnosis rate, so we will simply recognize what is current practice and will simply pass that right through.

So, to the degree that an individual hospital has a difference in terms of its current medical education costs and its current capital, then its actual final reimbursement would indeed include both its DRG rate payments and the capital and medical education costs. There would be variation within a city, but it would be based upon these passthroughs.

Additionally, we have felt that we need to recognize the fact that occasionally there are cases that are atypical and the patient may stay for a long period of time. We do not want to penalize the hospital for the small number of those cases, and we have declared that some of those will be atypical cases and we will recognize that in a payment for what we call outliers.

In addition, because our data base was on the basis of a few hospitals, we will exclude long-term hospitals, pediatric hospitals, and psychiatric hospitals, because, again, our data base did not include them.

I might say that our data for this was developed over an extensive period of time of some 10 years of study.

We also believe very strongly that there should be an incentive for the hospital. The incentive really is that our payment is in full if they can bring their costs in under the prospective rate. We do not intend to take back anything; we will recognize their efficiency. In other words, they get to keep the entire payment.

We will, however, prohibit against charging the beneficiaries anything additionally beyond what is allowable by law in terms of deductible and copayments.

One of our major aims, of course, is to reduce the administrative cost burden, because we find that the cost reporting burden right now is about 3,000 hours of time for each and every hospital. We

believe that we can significantly streamline that burden. We can't do away with it totally, because we do have to have outpatient services, capital, and medical education still on a cost basis. But we will reduce it significantly, which will obviously then give the institution additional dollars to move resources into their patient care component.

Last, it will be budget neutral. We intend to have the same dollars applied to the prospective payment proposal as they were to the Tax Equity and Fiscal Responsibility Act—TEFRA—so that in terms of one system or another, it is a budget-neutral system.

Now if I could move to your concern for quality of care, which we also share with you. Recently we completed our preliminary work in relationship to one measure of quality of care. Because of our concern, we commissioned a rather long and expensive study several years ago looking at quality of care in various States with prospective payment systems.

We used a very large sample, and we have roughly 6 years' worth of research, from 1974 to 1979, because we wanted to assure ourselves that we would get the trend lines prior to prospective payment in addition to the time for prospective payment development in the various States.

We sampled roughly 2,700 hospitals and about 700,000 discharges, so you can see it was a very expensive sampling technique.

I might say that this was an extensive long-term study; we spent about $5 million on it. The preliminary results have been reported at one of the professional association meetings. Our final study will be concluded and will be available for Congress during the summer months.

In the study, we asked very clearly that cases be identified which would be the ones that would have the most adverse outcomes; in other words, the sickest cases were picked. And so a panel of physicians and hospital administrators identified roughly 59 diagnoses, such as a stroke, a heart attack, or a severe burn—those diagnoses that we felt would be the first to show an indication of a diminution in quality.

We felt that if those diagnoses didn't show it, then other ones that were less critical or less serious probably would not show it either.

There was a diversity in programs. We had 11 separate programs that were examined, all of which had constrained costs, whether from an individual budget review, a case rate, or what have you.

Finally, they were adjusted for the severity of the hospital case mix in order to preclude a clouding of results.

Now, in terms of the indicators that we used, we looked at patient outcomes. We felt that there were several measures of patient outcomes that should be looked at. Inpatient hospital fatality rates and what we call our composite fatality rate, which meant we went beyond the hospital stay and looked at what occurred in the first 90 days after the individual patient went home. I might say that all our patients who were examined were part of the medicare sample, so they were the same population that we would be covering now.

We also looked at the readmission rate. And then, finally, as another measure, we looked at the number of registered nurses per

bed, because there have been some presumptions that perhaps the number of registered nurses might be concentrated downward to stay within the cost constraints.

May I just very briefly show you what we found? In terms of those cases that were the most sensitive—in other words, again, those that had the highest possibility of having a fatality—we picked the most severe ones, you can see that over the years, keeping in mind that roughly 1975, 1976, and 1977, were the beginning years of prospective payments, that the trend line is downward both in our control sample and in our actual sample of those that had a prospective review system.

Now, if you adjust these for the higher case mix that was prominent in the prospectively rated States, you will find that the two lines actually converge.

Chairman HEINZ. Now, on your charts,[1] the blue line is—both lines are medicare, the blue line is in the States that have a prospective method of payment, and——

Dr. DAVIS. And the other is in the States that have control.

Chairman HEINZ. Now, what States would those be for medicare?

Dr. DAVIS. Some of the States would be Massachusetts, New York——

Ms. FEINSTEIN. Western Pennsylvania, New Jersey, Arizona, Connecticut, Minnesota, Nebraska, Washington, Rhode Island, and Wisconsin.

Chairman HEINZ. About a dozen States or large metro areas such as western Pennsylvania.

Dr. DAVIS. Yes; that is correct. Again, in terms of looking at readmission rates, there was no significant difference between the control and the prospective payment, again recognizing that we had to collapse these back down to recognize the case mix. Once you do that, the lines are superimposed. For our process here, we were trying to show—as you can see, the trend is downward. And once the prospective system came into being, it made no difference, the trend line in terms of readmissions was still down. In fact the national average is at roughly 18 percent, and you can see that they were significantly down below that.

One final factor was the number of registered nurses per bed. I think there has been some fear that perhaps under a cost-constraining system that hospitals might begin to look at the staffing and might decide to decorate their registered nurse staff. Clearly this does not show that, and you can see that over the years the trend line is up, both in the States that had prospective payment as well as in the control sample.

Chairman HEINZ. Now, what is the basis of the acquisition of that information?

Dr. DAVIS. The basis of the acquisition of all of this information was from the data that we had from our 2,700 hospitals that were trended over that period of time.

Chairman HEINZ. Now, in Texas, as we heard earlier, in 1980, the system reflected—a system which was covering both medicaid and medicare—was reflecting the fact that there were no nursing

[1] Retained in committee files.

shortages in the Autumn Hills Nursing Home. GAO went in and found very substantial shortages.

Dr. DAVIS. Senator Heinz, let me clarify one thing.

Chairman HEINZ. Now, there may be a difference in reporting systems.

Dr. DAVIS. No; I think there is a difference in the system that we are talking about. We are talking about a hospital system, because this was a study done to look at hospitals.

Chairman HEINZ. I understand the difference; these are acute care hospitals and those are nursing homes—I do understand that. But nonetheless, both are health care facilities, they are both being examined to a certain extent by the same kind of system.

And my question is: If the system should be so off base in Texas, what assurances do you have for us that this is a magnitude better?

Dr. DAVIS. I think there are several factors. No. 1 is that we do have a survey and certification process, and, as you know, the Joint Commission on the Accreditation of Hospitals—JCAH—deems for most of the hospitals—they clearly go in on a yearly basis and do their sampling; on those hospitals that are not JCAH-accredited, we visit to look at their records.

But I believe that our study itself used actual data from the hospitals, and we have administrators and physicians as part of our advisory group that looked at this. So it's a very controlled sample and very detailed. I might say it cost us quite a bit of money; we spent $5 million on it. But we felt it was very important to assure ourselves that we did not see any diminution in quality during this period of time.

Chairman HEINZ. Please proceed.

Dr. DAVIS. Let me continue by just summarizing my statement in two areas.

There are two parts of the statement that I would just like to call to your attention. One is that in relationship to the two areas that we felt most important to look at, we have an admissions pattern monitoring system in which we are now comparing admissions to hospitals and the lengths of stay with patterns over a period of time in comparable calendar-year periods. We will continue to report on those patterns through our fiscal intermediaries. My staff will be looking at those reports every quarter or every month, so that if we do find any aberrant patterns, we can investigate and then take steps to correct them.

Second, we also have identified in the testimony several tools to monitor the appropriateness of admissions and days of care within the hospital system.

I would also call to your attention that we have recently published the NPRM's for revising our hospital conditions of participation for those 1,500 hospitals that do not come under JCAH accreditation but rather under our own. Those regulations, as you know, haven't been modified since 1966 and there have been significant changes both in medical practice and in hospital management since that time.

We are proposing to upgrade and consolidate a number of requirements particularly in the areas that relate to high patient risk. Likewise we are proposing to establish new quality assurance

conditions so that the hospital will have to have a written plan, an evaluation of all of its various services, an evaluation of its surgical area, medication therapy, and nosocomial infections—nosocomial infections meaning those infections that are caught as a result of being within the hospital environment.

Not only does a hospital have to keep a written plan that identifies each of those areas, but it needs to keep in written form what remedial actions it is taking, and document those, as a result of identifying any deficiencies in the system. And since that is a condition of participation, it means that if the hospital is not in compliance we could take steps to remove it from the medicare program.

I would also point out that our quality requirement is analogous to the JCAH's which has had a quality assurance regulation—quality assurance performance measure—in its own standards since 1979.

I think, too, that our survey process is designed to look at the health and safety environment in which quality of care can be delivered.

Through these measures, we believe that we are actively concerned about quality and are taking all steps we can to assure ourselves that the prospective payment system that has been developed for hospitals does take quality into consideration.

Finally, in conclusion, I would just like to recognize the fact that Congress did ask us to develop a prospective payment system for skilled nursing facilities, and we are developing such a plan. We are looking at it now. We are using our best resources within the agency and are talking with the industry, and we will shortly be formulating some options. And we would be willing at that point to talk to your staff about these before we move into a final development phase.

But our current system is for hospitals only, and we expect that we would have the system for prospective payment for nursing homes, which has been requested by Congress, to you some time during the summer months.

[The prepared statement of Dr. Davis follows:]

PREPARED STATEMENT OF CAROLYNE K. DAVIS

Mr. Chairman and members of the committee, I am pleased to be here today to discuss with you the Department's proposal for a prospective payment system under medicare and in particular, its quality assurance aspects. This plan, for hospital payments only, provides a significant opportunity to achieve our mutual objectives: To encourage hospitals to provide patient care efficiently; to allow medicare to become a prudent buyer of services; and to assure the quality of patient care.

High quality hospital care has a longstanding tradition in this Nation. Our prospective payment system will enable us to maintain our commitment to that tradition. While quality of care is difficult to define precisely, indications are that the same level of quality has been maintained in States which administer hospital prospective payment systems.

Specifically, the Department has sponsored a major evaluation of State prospective payment systems, one aspect of which concerned quality. The study covered a 6-year period from 1974 through 1979, and analyzed 670,000 medicare discharges from 2,700 hospitals. The discharges are from both prospective payment and nonprospective payment States. It examined the provision of ancillary services, changes in the scope of services, mortality, morbidity, readmission rates, and other measures of quality. The preliminary analysis shows no deterioration in quality of care in States with hospital prospective payment systems.

In fact, our prospective payment proposal may enhance the quality of care provided to medicare beneficiaries. This system has the advantage of encouraging hospitals to specialize in those types of cases which they can treat efficiently and effectively. Most studies have shown that as hospitals specialize in providing services, the quality of care improves. This is because some procedures require a high volume of cases to maintain proficiency in treatment. The studies indicate that when these services are provided in hospitals with low volume, quality of care suffers. In addition, certain unnecessary services, some of which would not improve patient health, might be eliminated as hospitals and physicians have strong incentives to provide care more efficiently.

However, we are aware that in any financing approach there are quality issues that need special attention. For 15 years, the medicare retrospective cost-based system of reimbursement provided incentives for hospitals to spend—not to constrain costs. In particular, this system has encouraged excessive hospital service utilization, which has been reflected through long lengths of stay and overuse of ancillaries.

Significant changes in reimbursement have been made under the authority of section 101 of Public Law 97-248, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Until enactment of section 101, positive incentives within the medicare reimbursement system for providers to carefully examine lengths of stay and use of ancillaries did not really exist.

In recognition of this situation, Congress, through section 101, extended the scope of the limits on allowable costs paid to hospitals for the care of medicare patients. The new cost limits apply to total medicare inpatient operating costs per admission. In establishing the limits, each hospital's cost is adjusted using a case-mix index based on diagnosis related groups (DRG's). Previous limits applied only to routine hospital costs and did not include the cost of ancillary services which account for about half of today's hospital bills.

In addition to the new cost limits, the TEFRA provisions establish target rates which limit the amount by which a hospital's reimbursement per admission can be increased each year. In the first year, hospitals over the target rate lose 75 percent of the costs over the target. Hospitals spending under the target rate will be allowed to keep one-half of the savings (not to exceed 5 percent of the target rate).

Because of the per case approach, TEFRA removes some of the incentives for excessive utilization. Some new potential issues could arise, though, such as:

Patient shifting from hospital to hospital in order to maximize the per case reimbursement; and

Increased readmission rates due to too-short initial lengths of stay.

We have taken steps, which I will describe momentarily, to address what we think will be the problem areas of quality assurance maintenance under the TEFRA changes. But I would add that I anticipate essentially the same quality assurance issues will arise under the prospective payment approach proposed by the Department as under any other prospective payment system. However, given the findings I mentioned earlier—that the various State prospective payment systems have not adversely affected quality—I believe these issues do not represent major problems.

I would now like to turn to our quality assurance safeguards. There are two major components to our approach. They are: (1) Detailed admission practice monitoring by HCFA staff and our fiscal intermediaries; and (2) improved hospital conditions of participation with enforcement through the survey process.

For the past decade, admissions and length-of-stay reviews have been primarily a responsibility of professional standards review organizations (PSRO's), and there has been a dramatic evolution over the years in pioneering the development of new techniques for identifying inappropriate care and changing physician behavior. When the program started, every medicare patient was reviewed.

It quickly became evident that this approach was both unnecessary and costly. The question then became how to target review. Various methods of physician and institutional profiling were developed. New instruments were prepared for obtaining data on inappropriate care, and these instruments have been tested in many settings. The spinoff from this work has been the identification of methodologies that we believe can be applied through less costly means that the continued use of PSRO's or the establishment of a similar professional review program as envisioned in TEFRA. Many of these new monitoring techniques are highly dependent upon data analysis, an area in which both we and our contractors have considerable expertise.

The first aspect of our safeguard plan, which we are already initiating under TEFRA, called "admission pattern monitoring." Based on bill data submitted to us, hospital admissions and lengths-of-stay patterns will be compared for comparable

calendar year periods. If the comparison reveals some aberrant pattern, the information will be submitted to our local medical review agent (today a PSRO or fiscal intermediary) to investigate and to determine the steps that need to be taken to correct the problem.

In addition to the admission monitoring systems described above, our concerns about TEFRA incentives to increase admissions have led us to examine alternative mechanisms to curtail inappropriate hospital utilization.

Two new sampling instruments have been developed for use in objectively identifying inappropriate hospital use. The instruments have the advantage of being so direct that they can be applied successfully by a wide variety of health care professionals.

The first of these two tools is known as the appropriateness evaluation protocol (AEP). The form is easy and quick to use in assessing both the appropriateness of an admission and the days of care spent in the institution. The form is targeted for assessment of care provided to patients admitted into adult medicine, surgery, and gynecology services. A limited number of explicit questions were developed for indicating whether a particular day of care was appropriate. The items are categorized into three areas—medical services, nursing/life support services, and patient condition factors.

Another survey instrument, called the standardized medreview instrument, is in the final stages of testing, and it holds great promise for identifying inappropriate admissions and hospital days. It combines the AEP survey form and other health care indicators and so provides still another useful tool for monitoring hospital practice. As a more sophisticated approach, it could replace the AEP.

The other major approach I wish to mention is our hospital conditions of participation. They set out a series of basic criteria, referred to as conditions, which a hospital must meet if it wishes to participate in medicare. The conditions have not been modified substantially since they were originally promulgated in 1966. Medical practice and hospital management have changed dramatically since that time. In our NPRM published on January 4, 1983, we are proposing to upgrade and consolidate requirements in areas representing high patient risk into a new quality assurance condition. It will require each hospital to have a written plan: To evaluate all organized services, nosocomial infections, medication therapy, and surgery. In addition, hospitals would be required to take and then document remedial action to address any deficiencies. It is this condition that would enable us to mandate corrective action. Failure to met this new condition would lead to exclusion from the medicare/medicaid programs.

Through our survey process we assess compliance with our hospital conditions and standards. The survey basically focuses on seeing that a healthy and safe environment is maintained and that a setting is present in which quality care can be delivered.

The Joint Commission on the Accreditation of Hospitals has had in effect an analogous quality assurance requirement since 1979, and in its interpretive materials for its surveyors has emphasized the importance of a hospital's quality assurance program in determining its accreditation status.

I hope you have found my commentary useful in understanding how we are approaching quality assurance issues under our hospital prospective payment proposal. Also, as you are aware, TEFRA requires us to develop for the consideration of the Congress a prospective payment plan for skilled nursing facilities. We are working on such a plan and anticipate forwarding it to the Congress this summer. We are carefully considering quality of care issues in the development of this plan so that we can continue to assure that the care provided to our beneficiaries meets quality standards.

Chairman HEINZ. Dr. Davis, thank you very much. As I indicated in my opening statement, you are moving ahead, as we in Congress have asked you to do, with a prospective reimbursement system, and I think I would be remiss if I did not compliment you for doing exactly that. Sometimes things that we ask to have done don't get done. I know that, in fact, HHS and you specifically have really worked very, very hard to try and meet the deadline—it happened to have been December 31—I don't fault you for not meeting it, it was probably an unrealistic deadline. I know you haven't in any way slacked off; to the contrary, it was just a very ambitious deadline.

And I do commend you for the work you have done. Obviously you want to send us implementing legislation. When do you think you will do that?

Dr. DAVIS. Well, the implementing legislation for the hospital prospective payment did leave our office several days ago and the Secretary signed off on it. And so it's in the usual process of clearance before it comes to the Hill.

Chairman HEINZ. It could take days, it could take——

Dr. DAVIS. No; I think it won't take too long; I expect you will see it in the next week or so. It is on a fast track.

Chairman HEINZ. I am not going to get into some of the questions that we got into with my colleagues, and the Finance Committee got into the other day. There are some significant issues involving "creep," not just among DRG's, but there is some concern about what is now covered under part A being shifted to part B. There is the issue—again, I don't choose to get into it today—of shifting costs from medicare to the other intermediaries and other plans and programs. Those are all real concerns, you are aware of them, and we needn't get into those.

I do want to focus in on quality of care, though, because that is what you have addressed yourself to, in particular here. And as I understand what you are really saying, there are two things that you are going to do to insure quality: One, is you are going to have stronger conditions of participation, and, second, you are going to do, as you described, a certain kind of intensive computerized analysis.

Now, Mr. Allen and Mr. Duffy, who are from New Jersey where you have both a hospital and a medicare experiment, have been here just a few minutes ago—you probably heard them. And what they are saying is that there are certain kinds of things that you just can't catch with a computer. You were here present for their testimony, I believe, were you not?

Dr. DAVIS. No; I was not.

Chairman HEINZ. One of the things they pointed out is that without real-time peer-group review you can't catch problems before they become serious, and, as a result, if you do catch things through computer analysis, what you are likely to catch is dead people after they have been killed, as opposed to preventing people from being misdiagnosed, or mistreated, or misadmitted, which has implications not just for their health but also for your cost system.

Why do you believe that your computer system—particularly given the kind of incentive that is involved here, namely, an incentive, which I think you yourself would admit is one to minimize the delivery of certain kinds of services—ancillary services—is going to head off these problems at an early enough stage so that we can say this system truly works.

Dr. DAVIS. Senator, one of the reasons why we chose the diagnosis-related group system is that it does offer to each and every individual hospital the ability to manage its own resources, because it gives back to the hospital a clinical assessment tool.

And what we have found—and I, indeed, last week visited New Jersey and talked with a number of physicians from various hospitals—what they had told me was that using that clinical data base coming from the DRG's themselves, they do their own peer review

within their own particular part of the system. It is to their advantage to do that, because, as you recognize, we are paying a set amount of money. While that set amount is calculated on an average, we think that the activities that they do to try to minimize or eliminate unnecessary services and testing, and to identify complications, if there are any, at a very early point, are those kinds of activities that also mean that they are concerned about quality. It is to the individual institution's advantage to be concerned about quality of care because, if they are not concerned, then the individual patient perhaps would have to stay longer and that patient's care would eat up more of their resources.

So I think the incentive is for the individual institution to assess quality very carefully. And we know that that does go on in the institutions in New Jersey.

Second, there has been an implicit assumption that when we move to a diagnosis-related group system, because the hospitals might have a tendency to look at the length of stay and perhaps have the individuals go home, say, a day earlier, that that means there is less quality. The Congressional Office of Technology Assessment has a draft report which I believe will be being finalized shortly, that speaks to the outcome measures of length of stay versus patient outcome. They found no correlation between the decrease in the length of stay and patient outcome, so I think we have to be very careful that we don't equate the wrong components here.

Chairman HEINZ. If your system on measuring outcomes is good and reliable and is related to the right DRG's, if the DRG's, in fact, are reflective of what should have been diagnosed in the first place, that's reasonable. But what troubles me is that you are, among other things, proposing to zero PSRO's. It seems to me there is no assurance that PSRO's, therefore, will continue, and it seems to me that just one barrier that would normally stop misdiagnosis and trigger, in effect the validity of your system, is going to be missing.

How can this whole system that you have described here really operate unless there are PSRO's? They assure not just proper patient care, but they assure that quality information goes into your management information system. If garbage goes in, however, garbage will come out—and, unfortunately, it will be human garbage.

Dr. DAVIS. Well, I think that even Congress itself has recognized through various studies that there have been efficient PSRO's and inefficient PSRO's, and so, to that degree, there is that variable.

What I would like to point out, however, is that the DRG verification will be done through the fiscal intermediary. We have a medical review unit in the fiscal intermediary, which has been longstanding, that does medical review now.

We would use that particular group to look to verify the diagnosis. And it would take steps, then, to look behind if there were problems with that.

Chairman HEINZ. Hypothetically, now, what would happen to the system if it turned out, upon careful analysis—well, if it turned out after you implemented it that it was more expensive than the current system?

Dr. DAVIS. Because we are creating a system that is budget neutral to the current budget, I can't see how it would become more

expensive than the current system. Our charge all along has been to make it budget neutral. We would use the same dollar figures we are now using under TEFRA.

Chairman HEINZ. I think someone once estimated, back in 1965, that by 1983 the medicare system would cost no more than $5 billion. That was maybe before your time.

Dr. DAVIS. Yes; I understand your concern. Let me just point out that during the number of years of study that we have tracked prospective payment plans, those States that have had a variety of plans have shown us that clearly they bring costs down somewhere between 2 and 5 percent.

Chairman HEINZ. Well, let's take your New Jersey experience. What's been the experience in New Jersey with prospective reimbursement?

Dr. DAVIS. Our experience thus far, based upon our preliminary data results, is that they are indeed below the national average.

Chairman HEINZ. Now, have you looked at whether costs in New Jersey, compared to retrospective reasonable-cost-based method, are more or less than the prospective method? Have you analyzed in effect reasonable cost versus what has actually been paid?

Dr. DAVIS. Well, New Jersey is a demonstration program, so we do keep quite a bit of accurate data on all factors of it.

I do want to point out one thing, Senator, and that is that there are significant differences between the New Jersey system and our system. New Jersey's is not only an all-payer system, but it also incorporates outpatient services, capital, and medical education costs within its rate. So that it makes it a distinctly different system from ours. It operates, frankly, on that type of budget review because of these other areas that we don't propose to bring into ours at this moment.

Chairman HEINZ. Well, be that as it may, it may be more expensive, but if you look at what—if you were to audit a hospital and see what we would have had to reimburse them on a reasonable-cost method, and then you looked at what we are paying them under prospective payment today, what would you find in New Jersey? Would we be paying more or less?

Dr. DAVIS. In the aggregate, what we have found is that the hospital cost per capita in New Jersey is less than the national.

Chairman HEINZ. That's not my question.

Dr. DAVIS. I know. What we are waiting for is our final audit figures from them on the other.

Chairman HEINZ. Are you familiar with Mr. Tobey's memo?

Dr. DAVIS. Oh, yes.

[The memorandum referred to follows:]

Memorandum

Date August 9, 1982

From William Toby WT
Regional Administrator

To George Thompson
Associate Administrator for Operations

Subject Region II Experience with the Diagnostic Related Groups Program in New Jersey

As HCFA examines New Jersey's DRG program with an eye towards major revisions in national reimbursement policy, I would like to share our experience with that experiment. If there is one, overall insight to be gathered from our perspective, it is the following: in New Jersey, the waiver of the principles of reimbursement had impacted on other areas, such as the administrative burden, the lengthy implementation process, the role of utilization review, and the necessary audit procedures, etc.

In considering a reimbursement scheme similar to DRG for the nation, I would urge you to consider these recommendations with the implications for Medicare policy and to anticipate more realistically the changes in program administration. The following summarizes the recommendations which are contained in the attached paper.

Billing and Review Issues:

- Carefully designed instructions to hospitals for use of the DRG codes is essential, especially with regard to designation and sequencing of diagnosis.
- An increased review effort must be planned which will oversee the DRG coding process.
- More substantial monitoring of outliers is necessary.
- DRGs need to be designed to assure a very low percentage of outliers.
- In the case of outliers, pay on a cost basis instead of charges.
- A more innovative approach to utilization review and quality assurance than has been adopted in New Jersey is required.

Program Administration Issues

- The rate setting process needs to be simplified, perhaps by setting a single rate for each diagnosis which would apply throughout the locality.
- An appeal network would have to be established to handle the inevitable appeal of rates by providers.
- The program effort to be devoted to auditing needs to be determined and appropriate funding provided.
- The requirements for hospitals to seek recoupment of bad debts need to be duplicated on a national level.
- Extending present Medicare coverage of bad debts should be very cautiously considered because of the adverse impact of the economy on total bad debts.
- In any per case reimbursement system, certain policy issues, including waiver of liability and physician certification, need reconsideration.

We are grateful for the opportunity to share our experience with DRG as you plan for revision of national policy. As you consider the policy and operational implications of a prospective reimbursement system, I believe my staff can provide unique, continuing assistance to your efforts.

Attachment

Region II Experience with Diagnostic Related Group (DRG) Reimbursement Project

At the outset, our regional office was not consulted by the, then, Office of Research, Demonstrations and Statistics in the approval and initial development of this experimental reimbursement project, which uniquely requires all payors to reimburse hospital care on a per case rather than per diem basis.

Even so, because we recognized the potential of this precedent-setting project, we undertook a monitoring program designed to track developments so that the regional office could gain knowledge and contribute to the project goals from the standpoint of our substantial experience with the operations of the Medicare/Medicaid Programs in Region II.

For example, our staff testified before the New Jersey Rate Setting Commission on behalf of the Medicare Program in gaining payor differentials and discounts for prompt payments. They also served on a number of committees set up by the New Jersey Health Department in the areas of auditing, DRG reimbursement and claims. Most recently, our program validation staff conducted a study directed at the effectiveness of DRG program standards.

Over the past two and a half years, this complex and innovative reimbursement system has provided a number of valuable lessons for our policy makers.

The first is that the impact of the experiment on overall Medicare/Medicaid program administration is far greater than anticipated.

The second is that we need to guard against windfall profits at the expense of the programs and their beneficiaries.

The third is that payment based on type of diagnosis may create incentives for increased admissions and manipulations of ancillary services and secondary diagnoses in order to maximize reimbursement.

The fourth is that it is essential to involve all payors under a DRG reimbursement system in order to avoid shifting of cost.

The fifth is that the system requires an effective master data file prior to setting and adjusting the rates.

The following issues represent a clearer delineation of the problem areas encountered in our monitoring, which because of their cross-cutting elements, must be grouped under the general headings of DRG Billing and Review Issues and Program Administration.

A. DRG Billing and Review Issues

1. Potential for DRG Creep

The expression "DRG Creep" first appeared in the New England Journal of Medicine in June 1981. It addressed the impact on reimbursement of various techniques for sequencing discharge diagnoses. The article in question discussed how, to maximize reimbursement, a hospital had developed a computer program to determine the DRG for each patient, as originally reported, and then to redetermine the DRG by reversing the first and second diagnoses. The impact of selecting the costlier DRG for that hospital would have increased revenues by approximately 14%.

Our sense is that many New Jersey hospitals are including all diagnoses indicated in the patient's chart, including historic diagnoses and past surgical procedures, which do not impact on the patient's current hospital stay. This has continued despite the fact that the New Jersey Administrative Code states that "diagnoses which have no bearing on the treatment received during a current hospital stay are not appropriate for use in DRG assignments."

In April, 1981, the New Jersey Hospital Association distributed to member hospitals a listing of diagnosis and corresponding DRG rates to alert hospitals to the importance of ranking diagnosis and subsequent reimbursement.

A difference of opinion in this area between the Department of Health and a PSRO was brought to our attention. In a letter to one New Jersey PSRO, the Department of Health stated that hospitals' medical records personnel have the final responsibility in determining the principal diagnosis and the sequencing of secondary diagnoses for purposes of billing.

The Department of Health further instructed that where the physician has not identified all principal and secondary diagnoses, the Medical Records Department should search them out and that the physician need not be consulted. The PSRO had reservations about this policy stating that this practice allows for non-physician medical judgements. It further felt that this would lead to DRG Creep and the skewing of data to be used in any evaluation of the project.

Recommendation:

The above suggests the importance of providing very specific instructions to hospitals regarding designation and sequencing of diagnoses.

2. Accuracy of DRG Assignments

To assure that instructions are complied with, an effective review mechanism is required. PSRO's had begun to monitor DRG hospitals in March, 1981. One of their responsibilities is to review the appropriateness of the DRG assignments on a retrospective basis. The State has not specified the exact sample to be used nor has it issued guidelines for a statistically valid sample. The percentage of cases to be reviewed by the PSRO's as well as the type of cases has been left to the discretion of each PSRO.

In conducting the validation study on DRG, our staff looked at a valid statistical sample of cases from 3 hospitals in 3 different PSRO areas. It also re-reviewed a sample of cases from each hospital that had been previously reviewed by its PSRO. Two of the PSRO's had been reviewing DRG assignments on 1% of annual admissions while the remaining PSRO did a 3% sample.

The preliminary results of our review indicate that the PSRO review of assignments of DRG's was being conducted effectively. No differences were noted. However, our staff disagreed with the DRG's that had been assigned by the hospitals in 9% of the cases identified in our own sample. Our conclusions were supported by a PSRO physician. In all but one of the questioned cases, the basis for disagreement was the fact that secondary diagnoses were being included which, based on the chart reviews, had no bearing on the treatment received during the hospital stay.

Recommendation:

These review results reinforce the earlier-mentioned need for very specific instructions, as well as the need for an increased review effort in this area.

3. Incidence of Outliers

We are very concerned with the substantial percentage of cases classified as outliers. Under the DRG method, participating hospitals are reimbursed for the cost of inpatients' consumption of the facilities' resources, based on a predetermined range of days (trim points) within a length of stay for each diagnosis. When a period of hospitalization falls outside the trim points, either higher or lower, an outlier case results, and the hospital is reimbursed according to actual charges for the resources consumed. Since hospital charges generally exceed costs, outlier cases result in greater reimbursement.

Unusually long or short lengths of stay are considered outliers and are isolated statistically. It is estimated that in 1982 approximately 20% of all inpatient discharges are classified as "Trim-point Outliers." In addition, the New Jersey Department of Health has issued instructions that patients who satisfy at least one of the following conditions will also be treated as outliers:

A. Patients who discharge themselves against medical advice.

B. Patients who die while hospitalized.

C. Admissions assigned to DRG's with fewer than 6 merged abstracts and bills in the prior year.

D. Patients in any of the 74 DRG's deemed to have poorly-defined clinical characteristics.

E. Patients admitted and discharged on the same day.

New Jersey Blue Cross estimates that when the above types of outliers are added to the "Trim-point" outliers, approximately 30% to 35% of all inpatient discharges will be classified under the general heading of outliers. The impact on total reimbursement of this high percentage is thus of deep concern to us.

While the DRG demonstration project was being initiated in the State of New Jersey, a projection of approximately 2% of outlier cases was made, indicating a modest variable that would not involve significant expense. Obviously, this expectation was not realized.

Given the costly nature of outlier cases, and the need to analyze their nature and frequency, in order to consider refinement of DRG classifications, some form of monitoring of outliers is necessary. Since PSRO's were working closely with participating hospitals and reviewing the DRG cases, this responsibility would have most naturally fallen to them.

The recent expansion of the number of diagnostic codes from 383 to 467 should hopefully give greater accuracy to the coding process and hopefully help improve this problem area. The expansion of the codes has eliminated unclassifiable cases and includes several general codes for unusual diagnosis or combinations of diagnoses.

Recommendation:

Given the costly nature of outlier cases, and the need to analyze their nature and frequency, in order to consider refinement of DRG classifications, some form of monitoring of outliers is necessary.

The critical lesson for HCFA is to avoid such a high incidence of outlier phenomenon with any national program. Our suggestion would be to design DRG's to assure a very low percentage of outliers, mainly related to the statistical extremes, or to simply pay costs for outliers, instead of charges (which include markup) as in the New Jersey system.

3. Quality Assurance and Medical Review

As discussed earlier, DRGs introduce a different incentive to the care of inpatients: providing the least costly care for patients by avoiding unnecessary services. In itself this incentive aims at achieving what UR and PSRO's have aimed to accomplish.

If carried to the extreme, incentives exist in this system to manipulate ancillaries in order to maximize reimbursement. Similarly, premature discharges could occur to maximize reimbursement. Therefore, quality assurance review requirements should be focused on such potential trouble areas.

A system that introduces such an incentive requires a focused quality assurance program.

The eight PSRO's in New Jersey review the medical necessity, appropriateness and quality of care rendered to inpatients of acute care hospitals. They have developed focused review systems, to varying degrees, whereby certain groups of patients, physicians, or common diagnoses are subject to or exempt from detailed review based on utilization data. Cases that are exempt from review receive automatic certification for the medical necessity of the admission and payment for the services approved. All cases come under the scrutiny of the review system should their length of stay (LOS) exceed or fall below the trim points established for each DRG (outliers). Medical necessity of services, quality of care rendered and the appropriateness of the level of care are all reviewed during this process. These essential elements are also examined during retrospective and concurrent quality review studies and monitoring

visits. However, some under/overutilization of ancillaries is discovered during the concurrent review process.

Under the Federal program, the review process can be delegated to hospitals or conducted by the PSRO, should a hospital not meet the criteria for delegation. The Federal delegation status of a hospital also extends to their private, (third party) patients at present. Under New Jersey's Medicaid program, all review is non-delegated and is conducted by the PSRO's.

As discussed, it is possible for a hospital to maximize its reimbursement through increasing admissions and manipulating the use of costly but possibly necessary ancillary services. It is, therefore, our contention that PSRO's should emphasize admission review and review of the appropriateness of the DRG assignments when dealing with a per-case reimbursement system. They should incorporate the review of the appropriateness and level of ancillary services into their quality assurance programs. The review system actually proposed and implemented by the PSRO's in response to the Department of Health UR Regulation does not, in our judgment, sufficiently reflect the reimbursement system.

Recommendation:

A basic change in the reimbursement system, such as that implemented in New Jersey, calls for a more innovative approach to utilization review and quality assurance than that which has been adopted.

B. Program Administration Issues

1. Rate Setting Experience

Under the DRG system, the New Jersey Department of Health presents a Preliminary Cost Base for each provider for the Rate-Setting Commission (RSC) at the beginning of the current rate year. This Cost Base includes direct and indirect patient care costs, physician costs, net income from other sources, a capital component, and an economic adjustment factor. A hospital's Schedule of Rates is the average amount of gross revenue a hospital shall charge and payors shall pay per case for services related to patient care in order to produce net revenue equal to the Preliminary Cost Base. The Schedule of Rates contains financial elements which are fixed relative to patient case volume and others which directly affect the collection of revenue through per case payments or charges with the Schedule of Rates.

The Schedule of Rates is set such that all patients' rates are based on the cost of services received, including a proportionate share of the indirect financial elemental requirements of operating hospital facilities, plus adjustments to account for the apportionment of the full financial elements among payors based on Commission approved payor differentials. The Schedule does not include rates for outlier patients. Once a hospital's revenue needs are known, hospitals are required to align charges as necessary to meet those revenue requirements, based upon estimates of changes in direct patient care volume and case-mix as estimated by each hospital. Consequently the provider must seek adjustments from the Department of Health as the year progresses.

Experience in 1981 indicates virtually every one of the 66 providers involved in the experiment that year appealed their initial rates upon receiving them. The total amount allowed out of the $118,622,000 appealed was $48,443,000 - broken down as follows:

Component	Amount Appealed	Amount Allowed
Direct Patient Care	$22,488,000	$ 7,066,000
Indirect Patient Care	33,788,000	17,572,000
Other Fixed Elements	62,346,000	23,805,000
Total.....	$118,622,000	$48,443,000

The number of individual elements appealed by providers ranged from two to fifteen, with the provider seeking greater reimbursement in all cases. The most frequently appealed items involved DRG experiment project implementation costs and funding for projects receiving Certificate of Need approval.

These appeals are reviewed initially by the Department of Health, and, if unresolved, then by the RSC. Since the RSC is also responsible for all payor differential requests, the administrative workload is considerable. This workload necessitates resolution of rate appeals within 140 working days of filing.

Finally, the actual experience for 1982 for those hospitals which entered the DRG program in 1980 points out the tremendous difficulty of implementing this rate setting design which attempts to utilize the experience of case-mix and costs for a base year two years earlier in setting the current rates. New Jersey has trended the

1982 rates using indexes because it was not able to carry out the expected methodology. Our sense is that 1983's rates will reflect similar trending.

Recommendation:

Since the system is very burdensome, it would be extremely difficult to implement on a national basis because of the complex data and cost analysis factors. HCFA could simplify the rate setting process by considering developing a single rate for each diagnosis to be used for each facility in the locality. This approach could also eliminate addressing bad debts or fixed costs on a per facility basis, by accounting for added costs like bad debts in a uniform locality-wide manner. This in turn would facilitate annual revisions in the reimbursement rates. Expansion of DRG on a national scope would necessitate establishing an appeal network large enough in scope to process the seemingly inevitable appeal of rates by providers.

2. Reimbursement Trends and Audit Implications

We have in previous correspondence with Central Office raised our concerns regarding reimbursement experience with the first group of DRG hospitals in New Jersey.

While we anticipated that reimbursement would increase, a preliminary analysis of interim Medicare reimbursement for 20 of the hospitals which entered the system in 1980 indicates that 1980 costs (if computed under the traditional system) increased 9.7% over 1979 costs but reimbursement increased 16.3%. Traditional Medicare audits have only been accomplished on 2 providers but the results are significant:

Hospital	1980 Reimbursable Medicare Costs	1980 DRG Reimbursement	"Overpayments"
Morristown Hospital	$16,209,973	$16,601,405	$ 391,432
Hunterdon Medical	$ 5,317,321	$ 6,420,903	$1,103,582

While the percentage increase of reimbursement over costs may not be excessive given the facts that (1) the reimbursement method is

changed from a retroactive to a prospective system and (2) uncompensated care is being reimbursed, the substantial "overpayments" in the two completed 1980 audits indicate that, at least initially, the system may be quite costly. Moreover, an analysis of submitted but yet unaudited 1981 Medicare cost reports by those 41 DRG hospitals serviced by New Jersey Blue Cross indicates that DRG reimbursement exceeded Medicare costs in the total amount of $30.9 million. As these numbers merely represent submitted data, they may well increase substantially after audit.

Because of our reimbursement concerns, the New York Regional Office has initiated discussions with the New Jersey Department of Health, New Jersey Blue Cross and Prudential to develop a common audit agreement, the purpose of which will be to furnish HCFA with hard information upon which DRG's can be evaluated. An audit protocol has also been developed and is incorporated as part of the agreement. A draft document has been circulated to all parties, including the New Jersey Rate Setting Commission and the Hospital Association. We anticipate a signed agreement within the near future. When the first audits under the agreement are completed, we will have definitive information regarding cost and cost shifting, data collection, etc. We would have hoped that this all might have been accomplished earlier to assure the most effective use of base-line data for reimbursement purposes.

The question as to whether sufficient audit funds will be made available is only now being addressed by BPO and ORD for the New Jersey experiment.

Recommendation:

Our belief is that the need for auditing and commitment of funds should be built into the design of any national program of this nature. In the New Jersey experiment, these issues were not clearly addressed at an early point.

3. Bad Debts

As a result of concerns raised regarding reimbursement for bad debts under the DRG reimbursement method, our validation staff undertook a study of the collection efforts used by hospitals to minimize their bad debt losses. In addition, it reviewed the hospitals' procedures for identifying third-party payors.

Procedures in effect at 4 hospitals (2 suburban and 2 inner-City) were studied.

The study found that all 4 hospitals had effective procedures for identifying third-party payors. The hospitals required patients to provide financial information prior to admission. Problems did occur with patients who entered through the hospital's emergency room. Because of the types of injuries sustained, it was sometimes difficult to obtain the information.

In the collection area, all hospitals had good collection procedures in place. The hospitals aged their accounts receivable and followed-up where their payment requests were ignored. All hospitals had ongoing arrangements with collection agencies. Accounts were turned over to these agencies where patients refused to pay. In addition, where assets were identified, the hospitals did not hesitate to initiate legal suit.

The hospitals also provided free care in meeting their Hill-Burton requirements. Under this arrangement, patients who are not insured and do not have any resources but whose income is limited qualify for free care. As New Jersey does not have an HMO category, it is more difficult for patients to obtain Medicaid coverage. This factor results in additional bad debts.

Recommendation:

The data from our study suggest an increased amount of reimbursable bad debts as a function of the weakening economy in New Jersey. Any national program that thus included bad debts lines would have to be similarly aware of the impact possible of economic trends on reimbursement.

Conclusion

While we have raised a number of critical points, we are still mindful of the experimental nature of the New Jersey project and attempts being made in the state to improve the program. Our disadvantage is not having sufficient information for monitoring and analysis to make more definitive judgments.

Nevertheless, we believe our regional experience with institutional reimbursement in the Medicare and Medicaid programs, as well as our knowledge of payment procedures for Blue Cross and other payors, has helped us identify emerging strengths and weaknesses of the DRG program.

In addition to the insights already offerred, we would also point out that in the New Jersey DRG experiment, only the Principles of Reimbursement were waived. However, in any per case reimbursement system, other elements such as waiver of liability, physician certification, etc. should also be considered and addressed.

Also, we recognize the importance of having all payors included in the system to avoid problems such as cost shifting.

Last, we agree with the GAO recommendation to Senator Packwood in a letter dated May 10, 1982:

> "Medicare would need to continue using similar principles under a prospective reimbursement system if such a system were to have any assurance that reasonable payments are made. This is because reasonable prospective rates can only be set based on a knowledge of current reasonable costs of efficient and economic providers. Therefore, a set of rules establishing what constitute reasonable costs would still be necessary."

Chairman HEINZ. Now, in that memorandum he indicates, with regard to some hospitals he has audited—Mr. Tobey works for your Department, as I understand it—that if hospitals had been paid under the traditional reasonable-cost system in the 1980 reimbursement, that their 1980 reimbursement would have increased 9.7 percent over 1979 costs. Instead, under the DRG system in effect in New Jersey, the rate of reimbursement increased by 16.3 percent.

Now, I suspect you are familiar with that assessment. Do I understand you to believe that that is really inaccurate in some way?

Dr. DAVIS. Let me point out that he based his assessment on some early preliminary material that was based upon a coding, from which he extrapolated.

Ms. FEINSTEIN. Mr. Chairman, it's important to note from whence the data came. Like Dr. Davis says, that was on a system using the old DRG's; that was a study done in 1980, when New Jersey was operating a different set of DRG's than they are today.

Chairman HEINZ. Does that make any difference?

Ms. FEINSTEIN. Yes; it certainly does.

Chairman HEINZ. To what?

Ms. FEINSTEIN. The ordering of the secondary diagnosis in the first set of DRG's had a direct effect upon reimbursement; in the second improved set of DRG's, which is what New Jersey currently is using and what we are proposing to use, the ordering of diagnoses is searched electronically by the computer, and so there is no opportunity for manipulation in terms of payment by ordering a specific secondary diagnosis like there was in the first set.

In addition, New Jersey set out explicitly to pick up bad debts, charity, to spend more in certain institutions than in others, by design. And so we would expect that we would be paying more in certain institutions in that demonstration than we would have under cost-based reimbursement. In fact, that was the design of the study.

So none of those results are particularly surprising; in fact, they were planned for.

Chairman HEINZ. Now, Mr. Tobey goes on to say that he is concerned as follows—this is on page 5 of his memorandum: "DRG's introduce a different incentive to the care of inpatients, providing the least costly care per patient by avoiding unnecessary services. If carried to the extreme," he says, "incentives exist in the system to manipulate ancillaries in order to maximize reimbursement. Similarly, premature discharges could occur to maximize reimbursement."

Now, I gather, from what you have said, you agree with his assessment that these incentives exist, but you believe you have got a system that will deal with them, is that correct?

Dr. DAVIS. Let me point out that I think that some of his assessments were valid and some were not. We are trying to clarify for you which areas, because he based all of his assessment on the early work in the old system. His assessment was also based on a sample of three hospitals, which is a rather small sample to extrapolate to a national design. Since you have his memo, I am sorry that you didn't have our memo back to him clarifying where his——

Chairman HEINZ. We asked for all of those, but couldn't get them from you.

Dr. DAVIS. Well, I didn't hear the request, sir. I know that I sent the draft copy of the report up to you just a couple of days ago, as soon as it came to my desk.

Chairman HEINZ. There is no reason to discuss paperwork in public. We can compare notes on that later.[1]

Dr. DAVIS. OK.

Chairman HEINZ. But I don't think that Mr. Tobey is basing the comment that I just made simply on two hospitals; I think he is basing it on a lot of experience he has had with prospective reimbursement, and I think you are aware, as we all are, of the real potential difficulties with this system.

Dr. DAVIS. Any system that we develop would have some potential difficulties with it, because it is inherent in any system that somebody wants to beat the system and to improve upon their reimbursement. It is our job to put in as many guarantees as we can think of to close those loops. We believe that we have been able to do that with this system.

But we have also, in addition, tried to keep in mind that a very central part of this is the quality of care issue. Certainly from my background as a nurse, I believe very strongly in high-quality care, and I intend to insure that our agency does everything we can to protect the integrity and the quality of care in the hospital.

Chairman HEINZ. Dr. Davis, before I yield to Senator Melcher, let me say I do not doubt your sincerity on this. There is always, however, a tendency to believe that high technology can solve any problem—and sometimes it can and sometimes it can't. I think you have described a very sophisticated system.

But I am deeply concerned about the elimination or at least the zeroing out of PSRO's, what that would mean. Personally, based on what I have seen and heard, I don't see how we can avoid the kinds of problems, albeit they were with nursing homes, that we have had described for us at Autumn Hills and other places today, without some kind of really decent professional review operation.

And I suspect this is only the beginning of our discussions in this regard, by no means the final word.

Senator Melcher.

Senator MELCHER. Thank you, Mr. Chairman. Dr. Davis, did the Health Care Financing Administration seek any review of Autumn Hills for criminal acts?

Dr. DAVIS. I have been advised that it would be inappropriate for me to get into any discussion of Autumn Hills, sir, because of a possible grand jury investigation. I think it's inappropriate for me to comment on the specifics of Autumn Hills.

I would be happy to talk about the process of nursing home review in general.

Senator MELCHER. Well, in general, Dr. Davis, has the Health Care Financing Administration participated in any criminal investigations regarding nursing homes?

Dr. DAVIS. We do not participate in a criminal investigation. It is very possible that when we have done our look-behind surveys or

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[1] See appendix, item 3, page 134.

when the State agencies have done theirs, that the data from those have been used, or we might in our role turn something that we would find over to our Inspector General.

But it is not our role to participate in a criminal investigation per se.

I might say to you, too, that the reason why I am not prepared to talk at length about Autumn Hills is that at no time did I have an indication that we were going to be asked to speak about that. Our invitation clearly said come prepared to talk about quality of care as it relates to our prospective payment system.

And, again, I would be happy to talk about nursing homes generically.

Senator MELCHER. Well, Dr. Davis, I didn't come here this morning prepared to talk about Autumn Hills either, but we are talking about Autumn Hills because the subject matter has come up, and I am just asking you general questions.

Has the Health Care Financing Administration asked the Inspector General to review any nursing home for criminal charges?

Mr. KAPPERT. It is our responsibility and that of the intermediary and the State agency, as they go about the business of paying claims—and, in the case of the State agency, of reviewing facilities and so forth. If they do, in fact, see any kind of criminal activity or suspect criminal activity, they should make those kinds of referrals. We have indeed made such referrals, but I think it's the kind of thing, if you are looking for detail, that we would have to get you numbers and places and we would be glad to do that.

Senator MELCHER. You had made some referrals to the Inspector General on possible criminal involvement?

Mr. KAPPERT. Where we see the possibility, yes, we turn that kind of thing over to the Inspector General.

Senator MELCHER. How long have you been with the agency?

Mr. KAPPERT. I have been with the agency since its creation, and with the medicare program since its first day.

Senator MELCHER. Have you noted during that—how many years is that?

Mr. KAPPERT. Since 1965, 17 years.

Senator MELCHER. And during that 17 years, have any of the requests of the Inspector General to review something that might lead to criminal charges resulted in any indictment?

Mr. KAPPERT. I think we would have to go to him for the outcome of the referrals we make, but I certainly believe that they have, yes. Again, in terms of the detail, we would have to furnish that.

Senator MELCHER. The answer is "Yes." But you would know of any involvement you have had in recommendations to the Inspector General where they actually resulted in criminal indictments.

Dr. DAVIS. Well, we turn our files, when we have found something, over to the Inspector General's Office, and then they use those files, and they may go back in and do further investigative work.

Senator MELCHER. I understand that. Do we have your name?

Mr. KAPPERT. Kappert, Martin Kappert.

Senator MELCHER. Mr. Kappert, there are probably others like you, but you are fairly unique in my experience, having somebody

that has been with a program from its inception, in your case, 17 years. In my experience, it is rather unique having that type of experience in testimony before a Senate committee.

You would indeed know whether things that you have suggested to the Inspector General resulted in any indictments, any convictions. And I gather from what you have told me is that, yes, indeed, there have been some indictments and some convictions.

Mr. KAPPERT. Yes; I am certain there have been. I am simply not able to give you the details.

Senator MELCHER. Oh, I'm not asking you to. I just want an overall view.

Now, have any of those indictments or convictions, either one, been of a nature of a criminal charge based on an individual health—well, I want to be more specific than that. Have they been of the nature of an investigation resulting in an indictment because some individual had either died or was severely mistreated?

Mr. KAPPERT. My understanding is that the case testified to earlier today was advertised as being unique in legal history. I would have to say, again, probably not.

Senator MELCHER. First time.

Mr. KAPPERT. This is what it has been advertised as. I don't know the law in terms of whether anyone has been convicted under those circumstances.

Chairman HEINZ. If the Senator will yield, it is my understanding that the case of Autumn Hills is unique, the first time, I am told, that a corporation has ever been indicted for murder. And certainly it's got to be the first time a corporation has ever been indicated for murder more than once.

Senator MELCHER. Now, Mr. Kappert, one other question, maybe the last question.

In your experience, what you have been involved with at your level, turning some information over to the Inspector General, is it your judgment that the Justice Department has been cooperative?

Mr. KAPPERT. There was a time before the Inspector General when we did in fact work directly with the Justice Department, more often than not on individual practitioner kinds of things as opposed to institutions, although there were some institutional ones.

And, yes, we did in fact get cooperation from the Justice Department.

Senator MELCHER. Now, Dr. Davis, how big a staff does the Inspector General have?

Dr. DAVIS. I am not familiar with the total size of his staff. Recently, the Secretary, Secretary Schweiker, made a decision to expand his staff, and they did transfer 170 people from my agency to his in order to beef up his ability in this area.

I can submit for the record what the size of his staff really is, but I am really not totally conversant with it. But I know it was expanded.

Senator MELCHER. Well, Mr. Chairman, the reason I ask that question—I think it's one that the committee will want to thoroughly understand. With the emphasis on the Inspector General as being sort of the leading group within a department, having a responsibility for legal action, it's a real question of whether or not

within that group there are some people who are experienced in handling criminal matters and that they do indeed handle the criminal matters, or if they are not experienced in handling criminal matters, that they do indeed turn over investigations or findings to the Justice Department for criminal investigation, and indictment, and possible trial.

Chairman HEINZ. I think the Senator raises a very valid issue. This committee, in cooperation with the Senate Finance Committee, which is the committee of overall jurisdiction for medicare and medicaid programs, conducted, about 1½ years ago, a careful hearing, oversight hearing, as to the efforts of the Inspector General, as to his priorities, as to his staffing. I think it is fair to say that there was some discomfiture on the part of members of the Finance Committee, both Republicans and Democrats, that Mr. Kusserow was not adequately staffed to do his job, and that, in part because of that, he was unable either to make a sufficiently comprehensive and detailed series of recommendations to clean up fraud, and abuse, and waste in the system, and, second, to refer the quantity of cases to the Attorney General that we judged would be a more appropriate level of referral.

And it is probably once again time for our committees jointly to undertake such additional oversight.

Senator MELCHER. Thank you, Dr. Davis, and thank you, Mr. Kappert.

Chairman HEINZ. Dr. Davis, just to pursue one issue that Senator Melcher raised regarding the ability of HCFA to monitor quality of care. At Autumn Hills, which was a 100-percent medicaid facility, which the Federal Government reimburses about half of, there were in 1978, and in 1979, and in 1980, a series of deficiencies cited, some of a very serious nature, that should have been picked up and acted upon by the Department of Health and Human Services.

They included, among other things, nursing services, awareness of nutritional needs—and here we have a facility at which the allegation is that people died because they were involuntarily starved to death. That is the allegation.

On the deficiencies in 1978, one of the deficiencies is failure with respect to awareness of nutritional needs. In 1979, failures with respect to supervision of patient nutrition, failure with respect to menus and nutritional adequacy, failure with respect to frequency of meals. And again in 1980, failure with respect to awareness of nutritional need.

What is very difficult for us to understand is if there is some kind of system that is supposed to do its job, how, given just the publicity, let alone the management-by-exception reports that are generated, clearly have been generated by HCFA or some part of HHS, how do we explain to people that nothing happened, indeed that nothing has happened, that there has been no return of money to the Federal Government, there is no overwhelmingly convincing evidence that during this period there was any dramatic improvement in the operation of this facility—why should we have confidence that the system that you have described is going to be any better than the one we have?

Dr. DAVIS. Well, as you know, in the medicaid-only nursing homes, we do have the State agencies doing the surveying. Until

1980—and, I might add, it was about September 1980, when Congress did pass legislation that we had asked for—in fact, we asked for it in 1979, and Congress did not pass it until 1980 as part of a total package. They did give us authority to do what we call look behind. This is the first time that we had the authority as an agency to take what we considered to be paper reports and to say to ourselves, well, we would like to go into that facility ourselves and actually do our own investigation. We didn't have that authority until, I think, it was probably December 1980.

So that with enhanced look behind, we have been aggressively looking at the terminations, and in fact in fiscal year 1982, we terminated approximately 140 facilities, and there was at least more than a dozen of those where we had used our look-behind authority, I believe. There was disagreement, and we did proceed with several terminations.

I think also, at that point in time, we did not have our MMACS system, which is our automated medicare-medicaid reporting system that I know some of your staff did visit on line. We have made very vigorous efforts to get that system on line so that we can track deficiencies. We can now, as you know, by computer, track a period of years in terms of what deficiencies are, so we now I think, find ourselves in a much improved position from what it was back in the early days.

Chairman HEINZ. Let's assume for the moment the allegations about Autumn Hills are all true, let's assume that the allegations about Autumn Hills as presented by the former district attorney are all true.

Should we expect HHS to do anything ever about any of those allegations? We paid for half the costs. Services, if you believe the allegations, simply weren't delivered. People, if you believe the allegations, died. The taxpayer has certainly come out on the short end as well as the patients.

What do we do?

Dr. DAVIS. Well, Senator, as you indicated, these are alleged as yet, and until we have a grand jury decision, we will simply wait for their determination, except for looking at what we now have currently.

We are concerned about the current survey status.

Chairman HEINZ. You know as well as I do that HHS isn't supposed to wait for an indictment to get money.

Dr. DAVIS. No; the surveys that have been recently done have indicated that they are in compliance. As to what would happen in terms of the past actions, I would have to await what kind of decisions were being made by the grand jury, and we would then take that under consideration.

Chairman HEINZ. If we know that service hasn't been delivered, we don't have to wait for a finding of criminality.

What is involved here is a criminal action. That is a very different kettle of fish from the United States paying for services which it didn't get. What does HHS propose to do about simply the books not adding up, whether it's a mistake or not, involving criminal intent.

Mr. KAPPERT. During the time of an investigation, as now, we would be advised not to take any action because of the possibility

of jeopardizing a prosecution. If, as Dr. Davis testified, this were subsequently proven to be so, the avenue that we would have would be to attempt to take disallowances, as we call them, against the State for having paid for services that were never rendered, and the State in turn would then have to go back against the corporation to recoup. The prospect of that, I would think, would be pretty questionable.

Senator MELCHER. Would the Senator yield?

Chairman HEINZ. Be happy to yield.

Senator MELCHER. Isn't it true that this is the fourth grand jury, and that there was plea bargaining subsequent to the actions of other grand juries, findings of other grand juries? So there certainly was a gap in between the findings and the gap between the plea bargaining and a gap as compared to now, the fourth grand jury investigation, which is a result of a new action, as I understand it, by the newly elected district attorney.

Mr. KAPPERT. I am not aware of whether in fact there were gaps in that particular period, but certainly the thing was continuous, and, without getting any more into the depth of the whole thing, I don't think we had an opportunity at any time to intervene.

Chairman HEINZ. I must say, the testimony I have just received from you troubles me deeply, because what you are saying is, if somebody is indicted for murder, you cannot take any action to recover Federal Government costs, and that doesn't make any sense at all.

Dr. DAVIS. No; we are not saying that, sir.

Chairman HEINZ. Well, that's what you said.

Dr. DAVIS. May I clarify?

Chairman HEINZ. Please, I wish you would.

Dr. DAVIS. What we are saying is—we have the power that if we go in and visit a facility and if we determine that there is something that is life threatening at that moment in time, then we obviously can take steps to immediately remove the facility from being a part of the payment system. Likewise we would then notify others, as indicated earlier, if we discovered criminal actions.

However, when it is an allegation that something happened previously, until it has been proven that the allegation is so, then we have been told that we should not do something at that point in time. I understand what your concern is that we shouldn't pay for services if they were not rendered; and, indeed, if that allegation is proven so, then we would take those steps.

But at the moment, since there is a grand jury investigation, it is inappropriate for us to prejudge what the outcome of it would be.

Chairman HEINZ. You have just said exactly what I was afraid you had said the first time. Now, remember, we are talking about two different things here. One, we are talking about improper payments by the Federal Government and the State for services not rendered. All right, that is the issue that I am asking you as the person who makes those payments, or at least a portion of them to look at.

Second, there is a totally different issue, as I see it, which is that somebody else is alleging—in this case, the State of Texas—that there is something that goes beyond that. The State of Texas is charging that because certain services weren't delivered, that a cor-

poration is responsible for the deaths of people. That is what is being alleged.

That seems to me to be a very different issue and I don't understand why that should prevent you from doing your job.

What you have suggested is that the way for somebody to avoid getting into trouble and actually having to pay money back to the Federal Government for services they never delivered is to get into some kind of litigation, and HHS will just walk away from it.

Now, I don't think you want that happen, frankly.

Dr. DAVIS. Well, Senator Heinz, my job is to protect the integrity of the delivery of care and services at that moment in time, which I would take vigorous action to do. I would point out that the payments were made several years ago and it is an alleged fact, and I am afraid in terms of what I could do about it at this moment in time, because of the grand jury investigation—because we had been advised not to make an interference which might prejudge that. Then one ought to talk to the Justice Department about those kinds of activities.

Mr. KAPPERT. We simply don't have the facts that the grand jury has, to begin with, proven or unproven. I mean, we don't do the kind of investigations or develop the kind of data that they apparently have. We simply do not have that evidence.

Afterward, if it is so proven, then that evidence will exist.

Dr. DAVIS. I can assure you that we will monitor the situation very carefully.

Chairman HEINZ. Well, I hear you, but I don't understand why you can't tell the State health department to get you the facts.

Dr. DAVIS. They are part of the grand jury investigation.

Mr. KAPPERT. The State attorney general has advised the State not to give us anything as well.

Chairman HEINZ. Well, I am at some disadvantage—I am not a prosecuting attorney; maybe Senator Melcher was at one time, there are an awful lot of former prosecuting attorneys that are U.S. Senators.

Senator MELCHER. If the chairman would yield, I think we are getting into almost a perception here that—and I don't think you want to leave it here, Dr. Davis and Mr. Kappert—that unless the State of Texas says that, based on the facts of the grand jury, that there was no fraud in the use of the money, the Federal money, that you are not going to be able to do anything, or won't do anything. And that if this drags out for years, you will never be able to make a judgment on it.

I don't think you want to leave that impression. I think you want to leave the impression that there will be some significant facts revealed to you very shortly.

Dr. DAVIS. That's correct.

Senator MELCHER. And that based on that you will make a final determination whether Autumn Hills has defrauded the Federal Government of some money they should not have, Federal dollars. And it doesn't make any difference on that basis whether Texas agrees or not. You don't have to have Texas to ever agree on anything to collect U.S. taxpayers' money, if it's a question of fraud.

Dr. DAVIS. No; what we do have to do is be careful that we don't prejudice the case by taking precipitous action before their action is done. That is what I was trying to indicate.

Senator MELCHER. And I would like, on behalf of you, and on behalf of HHS, and on behalf of the U.S. Government—I would like to have it stated that indeed the Inspector General of HHS and the Justice Department are cooperating with the State of Texas on all of this investigation, is that not a fact?

Dr. DAVIS. I know of no reason why we would not cooperate with them, sir.

Senator MELCHER. Is that a fact or not?

Dr. DAVIS. Well, I can't speak for the Inspector General. He has not communicated with me in any way, shape, or form. I know Richard Kusserow and I am certain that he would cooperate to the best of his ability.

Senator MELCHER. I will state, on behalf of every citizen in this country, that the Inspector General and the Justice Department indeed do have a responsibility to carry out assistance and cooperation with this investigation in the State of Texas.

Dr. DAVIS. Yes.

Chairman HEINZ. I want to thank Senator Melcher for some excellent advice, which I hope will be taken fully.

Dr. Davis, I don't think we have any further questions. Thank you for coming. I anticipate that members of the committee and myself and other committees will want to work with you quite closely in assuring a system of quality assurance that is really going to work.

Thank you.

Dr. DAVIS. We would be happy to work with you on that, Senator.

[On February 24, 1983, Chairman Heinz wrote to Dr. Davis requesting answers to additional questions for the record.[1] No response has been received from Dr. Davis at time of publication.]

Chairman HEINZ. Thank you.

[On February 17, 1983, Chairman Heinz wrote to GAO requesting an evaluation of the extent to which HHS, in advancing the prospective system, took into account lessons learned in the New Jersey DRG experiments the Department had funded. GAO's response, dated June 15, 1983, is included as appendix item 5, page 149.]

Chairman HEINZ. I am advised by staff that we may have received a request from Robert Gay, president of the Autumn Hills Convalescent Centers, Inc., in Houston, Tex. He had requested the right to respond to any information presented here.

We certainly intend to accord him that privilege if he chooses to press it.

Is this Mr. Gay?

Mr. GAY. Yes, sir.

Chairman HEINZ. You are not obligated to, but you are certainly entitled to.

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[1] See appendix, item 4, page 148.

STATEMENT OF ROBERT GAY, HOUSTON, TEX., PRESIDENT OF AUTUMN HILLS CONVALESCENT CENTERS, INC.; ACCOMPANIED BY ROY MINTON, ESQ., MADDIE LOCK, AND RON PULLMEYER

Mr. GAY. I appreciate the opportunity.

Chairman HEINZ. Mr. Gay, I want you to do two things. I am going to ask you to swear as to your testimony, and I am going to ask you to identify those accompanying you.

Would you please rise and raise your right hand?

Do you swear that the testimony you are about to give is the truth, the whole truth, and nothing but the truth, so help you God?

Mr. GAY. Yes, I do.

Chairman HEINZ. Would you please identify your associates?

Mr. GAY. First of all, for any that might not know, I am Robert Gay of Houston, Tex., and I am the owner of Autumn Hills Convalescent Centers. On my left is Roy Minton, who is my attorney, and whereas I am going to do the presentation, I think there is at least one question that you asked earlier, that I hope you will ask again, dealing with the plea bargain agreement, that probably he could do a much better job of answering than I can.

Chairman HEINZ. Who?

Mr. GAY. Roy Minton.

Chairman HEINZ. What is his relationship?

Mr. GAY. He is my attorney.

Chairman HEINZ. I am sorry, the rules of the committee do not permit attorneys to respond on behalf of a witness.

Mr. GAY. All right, I will do the best I can with that question, if it comes up.

Chairman HEINZ. And the reason is, an attorney has a special relationship with a client and cannot speak for the client on the public record.

Mr. GAY. I would just ask him to answer a technical question.

Chairman HEINZ. Would you identify the other people at the table?

Mr. GAY. All right, on my right is Maddie Lock, who is the director of our nursing services; in other words, she works in our central office, supervises nurses that are assigned out of that office for training and for inspection purposes. And on the far right is Ron Pullmeyer, who is our executive director, and in charge of seeing that our policies are carried out throughout our system.

Chairman HEINZ. Please proceed.

Mr. GAY. All right, thank you. As I said, I appreciate the opportunity to come here, and in the interest of time I think I ought to probably start by getting into the various things that Mr. Marks brought up so that we can kind of go through these things rapidly.

I am a little disappointed that we couldn't have been allowed to come on immediately after he was up here, because I think it would have been much easier for you to understand our answers to his questions had they pretty well come in the same proximity.

I don't know whether Dr. Davis has left yet, but I wanted to let her know that I do agree with her position on the prospective payment system which I think your congressional committee is looking into and apparently moving in the right direction.

I also want to compliment her for her position on the impropriety of having this case, the *Autumn Hills* case, tried in a public forum like this when it is possibly going to be litigated in the courts of Texas.

But since it is, I do appreciate the chance to rebut some of these things.

Chairman HEINZ. The Chair would note that this is not being tried in a public forum. We have been very careful, I think, Mr. Gay, to make sure that anything that has been stated by the prosecuting attorney, or the former prosecuting attorney, has been characterized as an allegation. The Chair himself has repeatedly made that point throughout this hearing.

And I appreciate your sensitivity to the issue, and I am sure I would feel the same way as you do. I would also remind you that at the time that I announced this hearing, you were not facing trial, you were not under indictment—your corporation was not under indictment. You are aware of that?

Mr. GAY. Yes. We are not under indictment at this time either. A grand jury investigation is very possible. The indictments were only thrown out for technical reasons, and it may go back to a grand jury. In fact, we have asked that it be taken to trial so that we can quit being perceived as guilty without our side of the facts.

Chairman HEINZ. I understand, but just so the record is clear, I think you are aware that the time we scheduled this hearing a plea bargain had been entered into, signed, sealed, and delivered, is that not correct?

Mr. GAY. That's true.

Chairman HEINZ. And therefore at that time the committee had every right, indeed every responsibility, to look into the circumstances of what was, at that point, a completed case, and any reopening of the case that is taken since that time you have done on your own initiative, is that not right?

Mr. GAY. It's not exactly right; it's up to the Galveston County grand jury to take any further action.

Chairman HEINZ. Maybe I misunderstand the situation. But did not Autumn Hills request that the plea be vacated? Was that not on your initiative?

Mr. GAY. Absolutely.

Chairman HEINZ. Well, then, I think, to make sure the record is correct, you don't want to leave an implication that the grand jury asked you to reopen the plea bargain, as I think that implication was stated on the record. And I think you want to correct that implication, don't you?

Mr. GAY. Well, I'm not implying that I have asked them to reopen it or that they are going to. It just seems impending that they will.

I would like to have an opportunity to comment on the GAO report briefly after my comments on Mr. Marks' presentation, and possibly one or two comments on the HCFA position that was given by Dr. Davis. I hate to miss an opportunity.

Chairman HEINZ. Please proceed.

Mr. GAY. Mr. Marks presented a very, very horrible picture of Autumn Hills, and he did it quite eloquently. But I think you just

heard from a very unexpert witness, and I am a little bit amazed at the importance that you all put on his testimony.

Mr. Marks, you might not know, was but 27 years old, right out of law school, when he stumbled onto this little dust-covered file that he liked to tell the story about, and began working on this case. And he has worked on it for approximately 3 years. He has been very, very effective in presenting what he has to the grand jury, resulting in these indictments.

I might say that his boss, who eventually fired him, probably should have done it much sooner, is of the opinion that he has a very good knack for presenting 100 percent, well, 50 percent of the data. And this is exactly what has happened here.

Only one side of this case has ever been presented, and so I would like to have the opportunity to answer some of these points that he brought up as we go right on through.

He sort of started off by giving the story of the little file that he found, that nothing had really—there had been no action taken. Well, actually action had been taken. There had been a grand jury investigation of one of our employees who apparently had reported some shifts covered that really weren't covered, and there was a thorough investigation of this, and the grand jury no-billed my administrator. And it had not just been ignored, like he indicated.

He did come out with indictments that claimed that Autumn Hills was guilty of murder, that we knowingly and willfully committed murder of patients. Now, this is a serious accusation; you kind of have to wonder about this. I think maybe his lack of experience maybe caused him to not know the law, or research it through thoroughly, but this is what came out of the grand jury investigation.

I might say that he is very forceful in his presentation, whether his facts are right or not, and was able to convince the grand jury of this. I don't think he can do this in a courtroom. I don't imagine he will be there to do it, but I don't think anyone can.

And so this is why we had asked that the plea bargain be set aside so that we can get into the courtroom where both sides of this will be told.

There was some indication that 65 percent of the days were understaffed. We were adequately staffed, and in nearly all cases were in compliance with the State's requirements. Sixty-five percent is a ridiculous figure.

He talked about a shortage of food. Can you imagine a nursing home group, 17 nursing homes, Autumn Hills, in the State of Texas, closely located near Houston, that—I started this company 20 years ago and have been dedicated to good service—can you imagine that we would actually single out one of our facilities, and go out there and deny food to these people? We have a reputation among our peers, a high reputation among the State health inspectors, and we have a high reputation among the families that we serve.

The food shortage that he seemed to dwell on was the shortage of a formula that we serve, in this case Ensure. It's one of several brands. It's sort of like a little malt in a can, has about 600 calories or so—250 calories probably in a can. And Ensure is ordered by the

doctor very frequently when a patient is not adequately taking other food in.

And we would offer this as a substitute if the person just didn't like the meal; we will offer it as a supplement if we feel like the person is not getting enough food. But it doesn't mean that this patient necessarily has to have this supplement every day. It is only a supplement.

We had approximately 8 patients out of 120 that were tube feeders, they had a Levine tube inserted, and the only food that they did get would be through some type of liquid formula like this.

So the statistics that they have can certainly be proven erroneous when you get into a, you know, more thorough examination of what was available and what was required to be served.

He mentions that 61 percent of the time during this particular period were sanction days, in other words, action being taken against our company. Now, I know you all have just gone through some questioning as to whether anybody is doing anything about the terrible atrocities. Well, we did go through a period there where we had sanctions placed against us, and it doesn't necessarily mean that during this 61 percent of the time that we were out of compliance, or were doing anything wrong. This might mean that you may have a roach in the kitchen, and you might be placed on compliance for 30 days, and you get the roach out of the kitchen, you know, immediately—or you don't have a cover on a garbage can, which is something we are not supposed to do, have a cover off a garbage can. And so that would be one of the demerits and one of the things that you would be written up on.

So we may have sanctions placed on us; in other words, put on compliance, which means you have got 30 days to do this, to put the lid back on the can. Certainly we go right in there and do it.

So 61 percent of the time that we were under a sanction certainly didn't indicate that there were life-threatening situations going on at that time.

He speaks of the money gain, and, Senator, you have spoken of this several times, and I hope you will question me a little bit in detail, like you have done some others, as we get into that part of it. But you seem to indicate that you think I took $200,000, $250,000, that I shouldn't have gotten and I did something with it.

This is part of what the prospective system is all about, in that you are paid a flat rate for providing services, and you provide those services, and you get paid that money. I didn't get paid any extra money for doing any of these things.

And there were implications that, you know, trips were taken, that parties were given. Keep in mind, this is a large company: We have 17 homes, we have 1,000 employees, we have 1,800 patients, we have a rather large central office. A lot of these things that might show up as flowers, and liquor, and meals, and things like this, are normal things that are done in normal companies. When someone is sick in the hospital, you send him flowers, maybe it's a patient, maybe it's an employee.

And so certainly these are expenses that are warranted. It's just how they happen to get coded on our cost report that raised some questions.

Chairman HEINZ. Let me ask you about that. First of all, this was a GAO investigation, and it wasn't that GAO or the committee was claiming that these were not perfectly legitimate business expenses; these were put on some kind of a report which was purported to list these as medical expenses, is that not the case?

Mr. GAY. No, it's not exactly the case. Keep in mind, I have been in the business 20 years, and for 17 of those years I have worked in some capacity, either with the State organization or the national organization, in trying to develop a fair reimbursement system. Seventeen years ago, when medicare was coming in, they took the position that we want to audit—we want a retroactive system—and it involved lots of audits and it was a cumbersome system that eventually caused all nursing homes, nearly all nursing homes, to not even participate in the program.

The prospective system allows us to come up with a flat rate that the State agency tries to have to be fair, they want it to be adequate, to provide adequate service; and, needless to say, if you want to spend more money, you could get more service—the State is faced with that problem. If they want this much service, they have got to pay this much money; if they want this much service, they pay this much money.

So there has to be a balance between what is paid and the services that are rendered. If you want Cadillac service, you have to pay a Cadillac price.

So, in Texas, we used to negotiate for a flat rate—this is the system we were on 17 years ago. HCFA at that time was trying to encourage all of the States to move toward a medicare-type reimbursement; in other words, a retroactive system. I, and two or three other States, held out and said we just don't think it's a good system, not for the taxpayers, because it is not going to be cost containing.

And now we see many years later that most of the States have now come along with Texas and have a system that is very cost-effective. And I have to compliment the current administration for taking here again another step that might contain some of the costs of services to the elderly and to the needy.

In trying to arrive at this flat rate, we have to have something to go on. In the old days it was just horse trading; you did the best job you could to get your rate, and they did the best thing they could to beat you down. And we decided—and I was part of the group that did—that it would be much better if we had cost reports that everybody submitted on a uniform basis, and we would use that as the basis for determining a rate. It's a very logical way to do it.

And we started this, I think the first pilot was done in about 1976, and it has progressed through the years. The first year that our system was audited was 1978, and under our program the Federal Government required that one-third of all of the homes be audited. I volunteered that all 17 of my homes be audited. And I also volunteered that we would be the first ones to be audited, because I had knowledge of this, and the firm of Haskins & Sells was awarded the contract to do this. They had no idea—their workers had no idea of how to go about this, and we welcomed them in and we showed them the proper way, you know, to understand what the whole system was. It's a very, very complicated system.

So when we come up with that flat rate, it does not mean that I am going to get any more money than anybody else. And, as the report shows here, the $250,000 as referred here, did not affect what I got, it did not affect what anybody else got. But there seems to be the implication that I walked away with a lot of money. And I didn't. I got just what everybody else did.

And the implication is that, well, we probably did make lots of money. We measure the amount of money that you make normally as an amount per day. I made in that year, 1978, 15 cents a day—that is less than 1 penny an hour profit, for taking care of a very fragile, very sick, very elderly person. Now, if you think that is ripping off the Government, I think you are getting a good deal.

You also got into the point that we made 100 percent return on equity. This is a way that was looked at, at one time, by the State of Texas as a gage for whether the industry was in a healthy position or not. It is not a good way to look at whether you are making any money or not, because you can actually be in the nursing home business with no equity at all. You can lease a facility and you can borrow the money to operate. And you may have absolutely $1 invested, and your return on equity, if you made $2 profit, would be 200-percent return on your equity.

So forget that as a good gage for measuring profitability in a nursing home.

Chairman HEINZ. How much did Autumn Hills make in 1979 and 1980?

Mr. GAY. In 1978 we made 15 cents a day profit; in 1979——

Chairman HEINZ. No, in dollars.

Mr. GAY. In dollars? Well, if you have your calculator you can multiply that by 365 times about 1,700 patients.

Chairman HEINZ. Do you report to your shareholders?

Mr. GAY. I'm the shareholder.

Chairman HEINZ. Are you the only shareholder?

Mr. GAY. No; I have one good friend that is a shareholder.

Chairman HEINZ. So you are not a public corporation.

Mr. GAY. Right. And we do have audited statements prepared by one of the Big Eight firms.

Chairman HEINZ. Why don't you just submit those to the GAO?

Mr. GAY. They have been submitted; we submitted them to the GAO.

Chairman HEINZ. Fine.

Mr. GAY. I might say that the average amount that is earned by nursing homes in Texas during this particular year, I think, was $1.12.

[Chairman Heinz asked that the following information be inserted into the record: First, Texas Department of Human Resources meeting agenda and attachments, February 26, 1981, showing that for the period studied return on equity (profit) in Texas nursing homes was 33.8 percent, which exceeded every other industry studied;[1] second, April 27, 1981, Dallas Times Hearld article, "Texas Nursing Homes Turn Average 33.8 percent profit";[2] and third,

[1] See appendix, item 6, page 161.
[2] See appendix, item 7, page 174.

June 14, 1981 Austin-American Statesman article, "Do Nursing Homes make Enough Money?" [3]

Chairman HEINZ. Excuse me a second. In those audited statements, don't you have any recollection roughly of how much money the corporation made in 1978, or 1979, or 1980?

Mr. GAY. It will be very small.

Chairman HEINZ. What's small in Texas?

Mr. GAY. Well, say, $278,000. I know if you were a peanut vendor, you would say $278,000 would be a lot of money, but it works to be 15 cents a patient day—that's not a lot.

Chairman HEINZ. Please proceed.

Mr. GAY. OK. There was talk about a large number of deaths. Now, keep in mind this was presented to you by a very unexpert expert, and how he is able to determine whether there is a large number of deaths or not, I don't know. Every nursing home is different. And we have some nursing homes of these 17 that have very, very few deaths, because they are a type, they are an intermediate type facility that really don't take the acute cases; they are light-care cases, and you see these nice little ladies walking around, and it's just the way you would like to envision a nursing home being.

But all nursing homes aren't that way. And all nursing homes should not be that way.

This particular nursing home was a skilled facility, located very close to the large Galveston County Memorial Hospital, which was bulging with medicare patients being paid $300—and this is a point I wish you would really listen to, because this is part of what your committee is really working on. We are talking about cost-effectiveness, we are talking about a cheaper way of doing the business. And one place where there is an enormous amount of money wasted in the program, the medicare program, is where patients are kept in hospitals much longer than they need to be, at $300 a day or more, when they could be transferred to an extended care facility, and kept at approximately $50 a day.

This is where the bulk of the money is being lost. Only 2 percent of the money in nursing homes even comes from the medicare program. This is wrong; there should be much, much more of it, and you would save millions and millions and millions of dollars.

So I hope the committee will look into that.

The people that were dying—now, keep in mind, in an effort to make acute hospital beds available to people who need acute hospital beds, people are moved out of the hospital into our nursing home. We were one of two skilled facilities in this area, and we took these people.

Now, you are really not doing yourself a big favor by taking an extremely heavy-care patient that has a prognosis that is very, very limited; in other words, the patient probably may die in 2 or 3 weeks. And you go through the effort of taking this person in, caring for him—they are a terminal case, they have cancer, they die—we are not killing these people; they just died for $30 a day instead of dying for $300 a day. But that is not every patient in our

[3] See appendix, item 8, page 175.

nursing home. It is just that our proximity and our type of care in that facility allowed us to take care of that type of patient.

Chairman HEINZ. As I understand your concerns, your concern and the reason you wanted to appear is that you wanted to clarify on the record some of the things that Mr. Marks said. The two things you have mentioned—well, one of the two things he's said you have mentioned, and that is you have talked about the formula. The other allegation——

Mr. GAY. Talked about what?

Chairman HEINZ. The administration of the nutritional formula.

The other allegation that Mr. Marks made involved nursing shortages. Let me just clarify this, because we could be here all afternoon, and I can't have the hearing all afternoon, because there is another hearing in a couple of minutes, and some other committee that I have got to——

Mr. GAY. I hope I won't have more than 2 more minutes.

Chairman HEINZ. Well, I can't guarantee that; you have had about half an hour. But you can submit something for the written record, if you would like.

One of the most frequent criticisms that was made relates to nursing shortages. Now, criticism comes not just from Mr. Marks, but comes from State health agency, it comes from medicare records, and it comes from the GAO. Now, you denied that there weren't nursing deficiencies at Autumn Hills during this period.

Mr. GAY. There were from time to time; there are in all nursing homes.

Chairman HEINZ. All right, it has also been alleged, according to Mr. Marks, that the formula that you discussed was the only formula purchased by Autumn Hills; he alleged that it was not a supplement, although it may have been marked as such, but that for a number of patients it was the sole source of nutrients. And in those cases, I understand, the procedure at nursing homes, a tube is used and the nutritional supplement is administered; it is not a question of whether people want it or not, it is what they are supposed to get.

And are you stating, just so I understand you correctly under oath, that the necessary quantities really were on hand at this facility?

Mr. GAY. Yes; I am saying that we had enough on hand to do the job. He assumes that we have to give these people this formula all the time and that they are all tube feeders, and they are going to die if you don't put—there were only 8 out of all of these, out of approximately 33 people that were on some type of supplemental feeding like this. Some of them just hate the stuff and won't take it. And don't need it.

Chairman HEINZ. The other allegation that you objected to was the implication that you are making a lot of money out of this, and that somehow your financial incentives outweighed your commitment to quality care.

Now, let me just see if I understand the situation. The GAO essentially found in 1 year about a quarter-of-million-dollars' worth of what some people would call executive fringe benefits, expense account items. Nothing illegal about them per se, but they were expense account items, a quarter of a million.

You have indicated that the corporation made, as I understand it, about a quarter of a million dollars—you weren't too specific as to that.

What did you yourself, in addition to those, pay yourself? I'm sure you are going to have an idea of what you paid yourself during this period.

Mr. GAY. $100,000 a year.

Chairman HEINZ. About $100,000. Now, is the coowner of this also a paid employee?

Mr. GAY. No; he is not.

Chairman HEINZ. So we are not talking about nickels and dimes here; we are talking about a fair amount of money.

Mr. GAY. We are talking about 17 nursing homes.

Chairman HEINZ. Yes; we certainly are. But my impression was that you wanted to leave an implication that this is just pennies a day. Frankly, to most Americans a quarter-of-a-million-dollars executive expense account is a lot of money, a quarter-of-a-million dollars' profit is a lot of money, a $100,000 salary is a lot of money. You have a perfect right to it as long as you deliver quality care—you have a right to make an honest profit. No one is questioning that. You have a right to have fringe account or expense account benefits—no one is questioning that. You have a right to get a decent salary in 17 nursing homes—that is a lot of nursing homes.

But I don't want you to leave the implication on the record that this is just nickels and dimes either. That is what we want to be clear on.

Senator Melcher.

Senator MELCHER. Well, I think the point has come up, Mr. Gay, that out of this 17 nursing homes that—some of the testimony was presented to the committee that 15 of those 17 on review consistently were outstanding, but two were——

Mr. GAY. Thank you for bringing it up.

Senator MELCHER. But two were not.

Mr. GAY. That's right.

Senator MELCHER. And the allegations involved one of those two.

So I think we can all understand how in a group of 17, some are going to be better than others. I think what our concern is, if this one that is involved in the allegations was not better, what was the reason for it, and were there differences in that one that you are aware of yourself, and what was done to correct or to alleviate those conditions?

Because you had to be aware that there was a difference; you must have reviewed the findings and ratings. And what specifically did you do to try to bring this one we are concerned with up to the right level?

Mr. GAY. All right, you mentioned that there were two that did not qualify for a superior rating. One of them was this Texas City nursing home. We were in the middle of all of this, there were changes in personnel. It did not qualify. It is a superior-rated nursing home at this time. I have to point out that when we did have 78 percent of our nursing homes that were superior rated, the statewide average was only 30 percent superior rated. Certainly we get some credit for that.

Senator MELCHER. I think more to the point is the allegation—it seemed to tell us that adequate nutrition was not supplied in this one.

Did you not find that there were some shortcomings?

Mr. GAY. Absolutely not. We went in and did an audit on all of these things, the same as the GAO report here.

Senator MELCHER. And you found nothing wrong?

Mr. GAY. No.

Senator MELCHER. I'm not just speaking of the day you walked in. Did you find nothing wrong in the past, in the months before that?

Mr. GAY. Oh, yes. We always go into a nursing home and find something wrong. This little lady here goes in there just like a State inspector, and——

Senator MELCHER. I mean seriously wrong. I know there is always going to be deficiencies.

Mr. GAY. No, we didn't find anything seriously wrong in that nursing home.

Senator MELCHER. And you satisfied yourself that there had never been anything seriously wrong there and that the operation of that particular nursing home should have showed up just as well as all the rest of the comparable nursing homes—because I also understand that of the 17 you have, they are not all necessarily comparable, due to age group, type of patients that are in some of the nursing homes.

Mr. GAY. I am satisfied that was a very good nursing home and that we were giving good patient care there.

Senator MELCHER. And there was nothing to the allegations at all? Is that right?

Mr. GAY. She would like——

Ms. LOCK. I'm Maddie Lock. The allegations were made by an employee, a State employee, who had a grudge against our administrator. There was quite a few allegations made.

Senator MELCHER. Now, you are making an allegation that the State employee had a grudge against the administrator.

Ms. LOCK. There was quite a few——

Chairman HEINZ. Excuse me, I have got to ask that Mr. Gay only speak. He is the only sworn witness. And I am sorry, we cannot, particularly in a matter of this great sensitivity, allow unsworn testimony.

Mr. GAY. May I pick up from where she left off then, and say that during this time we had this unrest, we had unusually bad inspection reports that were instigated by an ex-employee of ours. And I don't want to be too critical of her, because I think she was not that bad of an inspector; I think there was just a personality clash between this lady and my administrator. I think both of them were at fault that this thing really got to this point. But this is the beginning point for all of these problems that we had.

She was subsequently pulled off as our inspector, and it was alluded to by Mr. Marks that somehow or another we were able to go around the backrooms and get her pulled off. Well, it's a State health department policy that your ex-employee will not be your inspector, for two reasons: One, they can be overly friendly, or they can have an ax to grind. And it should not happen. And Dr. Bern-

stein of the health department was right when he pulled her off. Things got better after that.

Senator MELCHER. Mr. Gay, the confusing part of this is that in a plea bargaining, it is my impression that you admitted to negligence.

Mr. GAY. No; and this is why we backed out, because the public perceived our admission of guilt.

Senator MELCHER. Please describe for us exactly what your plea was.

[Mr. Gay and Mr. Minton confer.]

Mr. GAY. It's hard to keep these attorneys quiet, you know. He says that Mr. Marks was given an hour to speak on this subject, and that we should, you know, hopefully be given the same amount of time, and that he would like to speak for 5 minutes on the plea bargain deal.

Mr. MINTON. Mr. Marks was the attorney.

Chairman HEINZ. Excuse me, sir.

Senator MELCHER. No, wait a minute.

Mr. MINTON. And I am the attorney for Autumn Hills.

Senator MELCHER. What was your plea?

Mr. GAY. It was a nolo contendere; in other words, we agreed not to contest this—now, this was a plea bargain agreement between us and Galveston County, so that we could finally put this thing to bed and get on with——

Senator MELCHER. Agreed not to contest what?

Mr. GAY. The plea bargain, which—their side of the deal was that——

Senator MELCHER. What was the charge?

Mr. GAY. The charge would be reduced to involuntary manslaughter, and that we would be put on probation for 10 years, and the judge, after 2 years, would rule not guilty in the case.

Senator MELCHER. And you agreed to that?

Mr. GAY. I agreed to that, yes.

Senator MELCHER. Now, the involuntary manslaughter would be on the basis of what? What was it that created the involuntary manslaughter?

Mr. GAY. It was on the basis of just getting out of the thing and getting back to business.

Senator MELCHER. No, no, I may not be explaining myself. You accepted that, and what would cause the involuntary manslaughter?

Mr. GAY. I don't know; I don't think that they could prove involuntary manslaughter, or negligent homicide, or anything.

Senator MELCHER. Did the district attorney charge in this plea bargaining, the Texas State Justice Department, did they say that involuntary manslaughter resulted from a series of negligent events at this particular nursing home?

Mr. GAY. This was the agreed indictment between my attorney and the district attorney.

Senator MELCHER. Now, you disagree with that?

Mr. GAY. Well, at the time we went into this, we were told by everyone, look, this is the best thing to do, you know, stop spending money, get on back to business, and we can get this thing put to bed.

And when we agreed to this, Maddie, and Ron, and my wife, walked out in the hallway and we said: Why aren't we happy? Supposedly it's over with now, why aren't we happy with this? Well, the reason we weren't happy is that we know that people are going to perceive this as an admission of guilt, and it stuck in our throat.

Senator MELCHER. Now, you are testifying today, not just on yourself, but on behalf of the employees, that to your knowledge there was no negligence at this particular nursing home, is that true?

Mr. GAY. Absolutely.

Chairman HEINZ. I have just one last question. Was the inspector of the State named Betty Korndorffer that you referred to?

Mr. GAY. Yes.

Chairman HEINZ. Now, did I understand you to say she had been an employee of Autumn Hills, is that correct?

Mr. GAY. Yes; that's correct.

Chairman HEINZ. Does the Clear Lake Care Center have any relationship to Autumn Hills?

Mr. GAY. No.

Chairman HEINZ. I am puzzled, then, because I am advised that that person was an ex-employee not of Autumn Hills but of Clear Lake Care Center, at least was also an employee of that facility at one time.

She inspected both that facility and your facility, you are saying, when she was working for the State?

Mr. GAY. Well, I can't say whether she was inspecting there, but she was inspecting another one of our facilities at the same time.

Chairman HEINZ. But she had been an employee of yours at one time?

Mr. GAY. At another facility.

Chairman HEINZ. And then she went to work for a second facility.

Mr. GAY. No; it was just the reverse of that.

Chairman HEINZ. She had come to you after she had been with this other place.

Mr. GAY. Yes. Keep in mind, we had no problems with Betty Korndorffer in this other facility; I am not trying to indict her for being, you know, an idiot by any means. She was not really a bad person; she just had a conflict with this particular administrator.

Chairman HEINZ. Well, Mr. Gay, I understand you do want to testify some more.

Mr. GAY. Can I wrap up with the GAO in about 5 minutes?

Chairman HEINZ. I cannot chair this hearing any longer. I apologize to you for that, it was not my intention. We had scheduled this hearing to end at 12:30.

We only found out yesterday about your intention to testify. We would be happy, however, to receive for the record any sworn statement that you care to make.[1] You have had, I think, some opportunity, perhaps not as complete as you would like, to put the facts on

[1] No additional statement has been received as of publication date.

the record. And we do thank you for being willing to appear—we appreciate it. And we thank your associates for observing the rules of the committee permitting you to put the case forward.

I must regrettably adjourn the hearing.

[Whereupon, at 2:12 p.m., the committee adjourned.]

APPENDIX

MATERIAL RELATED TO HEARING

ITEM 1. SUBURBAN MEDICAL REVIEW ASSOCIATION AND ESSEX PHYSICIANS REVIEW ORGANIZATION REPORTS, SUBMITTED BY DENNIS J. DUFFY, EXECUTIVE DIRECTOR, SUBURBAN MEDICAL REVIEW ASSOCIATION, INC., KENILWORTH, N.J., AND B. MARC ALLEN, EXECUTIVE DIRECTOR, ESSEX PHYSICIANS REVIEW ORGANIZATION, INC., SOUTH ORANGE, N.J.

OVERVIEW AND HIGHLIGHTS OF THE 1983 PROPOSAL

The proposal addresses all pertinent areas and functions of the SMRA's operation. It houses a description of the management operation of the corporation as well as the actual review system functions.

The plan demonstrates the SMRA's ability to perform DRG analysis, utilization review and quality assurance at a very reasonable cost. There are a few areas which will rely on hospital and Department cooperation. One particular area is the analysis section, where the SMRA must receive historic UB-PS data tapes and Hospital DRG Management Reports in order to deliver the analysis proposed.

A. The Review System - The Utilization Review function is performed by the use of a highly concentrated Admission Review Program which will look at all admissions except normal delivery and healthy newborns.

The Continued Stay Review Program will use the cyclic review system, with review being assigned for up to every five working days.

The Retrospective Review, or our Quality Review Study Program, will require two individual hospital studies and three areawide studies per year.

The system will also perform occasional special studies as deemed necessary. Special psychiatric studies have and will be performed. In addition, the SMRA has a Program Impact Section on the Utilization Review Worksheet which is utilized to document Nurse, Social Service and normal Peer Review Interaction.

The SMRA has a comprehensive program of Discharge Planning which is coordinated with the individual hospital personnel.

B. Monitoring and Oversight

The proposal demonstrates in detail the SMRA monitoring methodology which began with use of our delegation criteria and assessment of the area hospitals. This process continues through two formal monitoring visits at each hospital each year. The delegated hospitals are given the responsibility of performing review in accordance with our systematic requirements, and, if they continue to meet our compliance standards, they may retain their delegated status, according to our Monitoring and Delegation Plans. If these institutions do not perform well, they become subject to these same delegation criteria for removal of delegation.

The monitoring program has a simple basis; through the visits to the hospitals, we can identify problems and achieve their resolution through corrective-action plans.

This ongoing process of monitoring manages to keep the system running as smoothly as it should with the desired results.

C. Data and DRG Analysis

The normal Data collection (NJUP) and processing (South Carolina Medical Building) continues, but many DRG/case-mix reports and analysis sets have been completed to satisfy the Department's requests.

Three new sources of data will be used (if SMRA can receive clearance to get them); namely, UB-PS, Y-tape and selected DRG Management Reports. Through these data sources, the SMRA will attempt to analyze and evaluate the DRG system and be able to locate areas for concentration in the future. The analysis will enable the SMRA to evaluate the case-mix system within each hospital with the ability to compare functionally specific data on cost and quality. The Association will be able to perform areawide and individual hospital comparisons which should benefit the Department, Payor and Institution.

QUALITY ASSURANCE PROGRAM SUMMARY

During 1982, the SMRA completed four original Quality Review Studies (QRS) and three reaudits, performed one special study and conducted concurrent quality assurance for four surgical procedures. The following summarizes problems identified, action taken and impact demonstrated, where applicable, as a result of these studies.

1. Quality Review Studies

A-6 Urinary Tract Infection - The original study revealed problems in four major quality areas, as well as with documentaton in physician progress notes. Hospitals were required to conduct continuing-medical-education programs for physicians and inservice training for nursing staff. A reaudit was conducted in the summer of 1982, and impact was demonstrated in the following areas:

	Original Study	Reaudit	% Change
. Validation of Diagnosis (100%)	95 %	100 %	+ 100 %
. Indications for Catheter Use (100%)	74	88	+ 54
. Use of 3-way Foley (0%)	45	6	- 87
. Sterile Drainage System (100%)	40	80	+ 67
. Antibiotic Use (100%)	78	85	+ 32
. Documentation of UTI in Progress Notes (100%)	49	60	+ 22

A-7 Cerebrovascular Accident - A follow-up reaudit in 1982 on CVA indicated impact in the following problem areas:

	Original	Reaudit	% Change
. Referral to Rehab Services within 72 hours of admission	84 %	88 %	+ 25 %
. Referral to Discharge Planning within 7 days of admission	78	94	+ 73

A-8 Abdominal and Vaginal Hysterectomy - After implementing areawide and hospital-specific corrective-action plans, the following impact was noted at reaudit:

	Original	Reaudit	% Change
. Surgical Indications (100%)	98 %	100 %	+100 %
. Post-op Morbidity (0%)	26	15	- 42
. Urinary Tract Infection (0%)	9	4	- 55
. Wound Infection (0%)	4	1.3	- 67
. Use of P.A.T.	88	93	+ 42
. Length of Stay:			
. Pre-op (all cases)	1.6 days	1.7 days	
(elective)	1.4 days	1.1 days	-.3 day
. Total (all cases)	9.2 days	9.3 days	
(elective)	8.9 days	8.0 days	-.9 day

A-9 Permanent Pacemaker Insertion- Original study completed March 1982. Problems were identified in three major areas: 1) inappropriate indications for 5% of pacemaker implants; 2) high post-operative length of stay; and 3) lack of post-operative chest films. Incidental findings included inaccurate coding due to incomplete diagnoses recorded on the face sheet, and excessive variation between actual pacemaker cost (manufacturer charges) and hospital markup (patient cost). A reaudit will be conducted in March 1983, and will focus on the above-noted problems.

A-10 Acute Myocardial Infarction - Original study completed March 1982. Problems identified in the following areas: 1) inappropriate diagnosis of M.I. in 4% of cases; 2) high mortality rate; 3) inappropriate utilization of monitored beds. Hospitals were specifically asked to address the issue of appropriate bed utilization to alleviate bed shortages for critically ill patients. A reaudit will be conducted in April 1983, and will focus on the foregoing problems.

A-11 CAT Scans of the Head - Original study completed May 1982. No problems were reported on appropriateness of indications for head CAT scans. However, problems were identified regarding timely performance of scans and over-utilization of brain scans and EEGs. A reaudit will be conducted in early 1983 to monitor reduction in the time period for performance of CAT scans, to determine decreased utilization of brain scans and to assess continued appropriateness of indications for CAT scans.

A-12 Upper G.I. Endoscopy - Original study completed November 1982. Identified problems pertain to lack of indications for performance of endoscopies and lack of an upper G.I. series prior to endoscopy. A reaudit will be conducted during the latter part of 1983.

2. Special Study - Respiratory Complications

An in-depth study on the increasing post-op respiratory complication rate in cholecystectomy patients was conducted by SMRA physician and nurse reviewers during 1982. The study revealed a 12% documented rate of post-op complications (pneumonia, pneumonitis and atelectasis) occurring in high-risk patients.

Corrective action included the performance of continuing-education programs for physicians to instruct them in proper identification of high-risk patients, performance of pre-op pulmonary evaluations and prompt delivery of respiratory therapy when clinically indicated.

Concurrent monitoring of all cholecystectomy cases will be conducted during January and February 1983 to ascertain the effectiveness of the educational sessions and the decrease in the respiratory complication rate.

3. Concurrent Quality Assurance

A. The SMRA conducted a six-month concurrent quality assurance study addressing the medical necessity for performance of four major procedures: cholecystectomy, abdominal hysterectomy, vaginal hysterectomy and permanent pacemaker insertions. All cases were found

to be compliant with the criteria; it was determined that the procedures were being performed appropriately and were medically necessary. However, two cases were identified which noted positive radiologic findings for stones, but no evidence of stones was found during surgical or pathological evaluation. A subsequent chart review revealed problems at two hospitals and this issue will be addressed more fully during 1983.

B. In an effort to intensify review in psychiatry, the SMRA recently implemented a formal quality assurance psychiatric review program. Criteria were developed encompassing admission appropriateness, quality of care and identification of inappropriate lengths of stay. Specifically, the criteria addressed: 1) justification for admission; 2) treatment plan; 3) frequency and appropriateness of medications; 4) indications for ECT; and 5) administration of lithium carbonate.

To date, data have identified the inappropriate use of multiple psychiatric medications as a major problem area. Further investigation and corrective action will be taken by the SMRA in 1983.

Quality assurance plans for 1983 include an in-depth assessment of the quality of care rendered by mobile intensive care units (MICU) for patients with cardiac arrest. An areawide quality review study will begin in January 1983.

SUBURBAN MEDICAL REVIEW ASSOCIATION

AREAWIDE QUALITY REVIEW STUDY A-14

MANAGEMENT OF VENTRICULAR FIBRILLATION BY MICU TEAM

STUDY SPECIFICATIONS

I. OBJECTIVES

1. To determine the incidence of cardiac arrest among the MICU runs, and the incidence of ventricular fibrillation as the first cardiac rhythm disturbance.
2. To assess the timeliness of defibrillation and intubation by the MICU Team
3. To evaluate the appropriate sequencing of drug therapy in the management of ventricular fibrillation.

II. PATIENT POPULATION

Include: patients with ventricular fibrillation as first recorded cardiac rhythm; patients developing ventricular fibrillation as first arrest state rhythm.

III. SAMPLE SELECTION

Sample Size: 50 cases

Sex: Male and Female

Age: Exclude all patients under 20 years of age

Time Period: July 1, 1982 through February 28, 1983

Data Source: MICU Run Forms

IV. Items For Committee Information

1. Status on arrival:
   - . cardiac arrest or respiratory arrest (witnessed or unwitnessed)
   - . time CPR was started; by whom
   - . estimated anoxic time
2. Type of intubation (esophageal, endotracheal, oral airway)
3. Time of arrival of MICU Team
4. Duration of code
5. Patient outcome
6. Number and type of cases converted to other cardiac rhythms and transported to hospital in stable condition.
7. Weight

SUBURBAN MEDICAL REVIEW ASSOCIATION

AREAWIDE QUALITY REVIEW STUDY A-14

TREATMENT OF VENTRICULAR FIBRILLATION BY MICU TEAM

SCREENING CRITERIA	INSTRUCTIONS FOR DATA RETRIEVAL
1. Defibrillation Conducted: . within one minute for monitored cases . within five minutes of arrival for unmonitored cases	1. Monitored = patient on monitor and under treatment by team when conversion to ventricular fibrillation rhythm occurs. Unmonitored = Ventricular fibrillation occurs prior to arrival of MICU Team or prior to use of cardiac monitor
2. Initial defibrillator charge of 200 - 300 joules	
3. Repeat defibrillation conducted for persistent ventricular fibrillation (charge = 200 - 300 joules)	3. Defib x 2 - counts as two defibrillations
4. IV line established after defibrillation and within 10 minutes of defibrillation . Exceptions: a) IV started prior to occurrence of monitored ventricular fibrillation	
5. Intubation begun within 10 minutes of arrival of MICU Team or occurrence of monitored Ventricular Fibrillation	5. Specify whether esophageal or endotracheal
6. Epinephrine (Dose = 0.5-1 mg) given IV or endotracheal prior to 3rd defibrillation	6. Specify route: IV or Endotracheal
7. IV Sodium Bicarbonate (Dose = 1-2 amps) administered prior to 3rd defibrillation . Exception: IV unable to be started	7. Specify amount: 1 or 2 amps
8. Third defibrillation conducted with charge of 300 joules or greater	8. Specify charge

SCREENING CRITERIA	INSTRUCTIONS FOR DATA RETRIEVAL
9. Bretylium IV (350-500 mg or 5 mg per kg) or Lidocaine IV (50-100 mg) administered after 3rd defibrillation	9. Specify type of medication and dose used. Should state bolus; do not accept IV drip.
10. Fourth defibrillation conducted following Lidocaine or Bretylium administration with charge of 300 joules or greater	10. Specify charge
11. Second dose of Bretylium IV (at 700-1000 mg or 10 mg per kg) or Lidocaine IV Bolus (50-100 mg) given after 4th defibrillation	11. Specify type and dose of medication used
12. Second and subsequent doses of IV Sodium Bicarbonate administered At 10 minute intervals for duration of code*	12. Count time from onset of monitored ventricular fibrillation to transport or expiration
DURATION / MIN. DOSE / MAX. DOSE 9-10 min. / 2 / 3 11-20 min. / 3 / 4 21-30 min. / 4 / 5	Specify dose
13. Repeat doses of Epinephine (0.5-1mg) at least twice during first twenty minutes of code.	13. Count time from onset of monitored ventricular fibrillation
14. Fifth defibrillation conducted with charge of 300 joules or more	14. Specify charge
	15. Discontinue review of the code after 30 minutes of resuscitation for persistent V-Fib or after conversion to any other cardiac rhythm

SMRA Suburban Medical Review Association

660 NORTH MICHIGAN AVENUE, KENILWORTH, NEW JERSEY 07033 • (201) 688-2050

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MEDICAL DIRECTOR

February 1983

Hospital

New Jersey

Dear Dr.

During a recently completed areawide quality review study on "Upper GI Endoscopy", the Suburban Medical Review Association identified a possible aberrant practice pattern at your institution. Analysis of the Physician Profile revealed that the cases belonged to Physician

In accordance with Sections 1155 and 1160 of the Social Security Act, SMRA has overall responsibility for the identification of unusual patterns within the area and to insure that care provided is consistent with professionally recognized standards. Therefore, the SMRA Board of Trustees has requested that Physician meet with an Ad Hoc Peer Committee consisting of two members of the Gastroenterologist Subcommittee and the SMRA Medical Director. The purpose of the meeting will be to discuss the findings of the quality review study and the appropriateness of the indications for the procedure. It would be worthwhile to have available some of the records for suitable discussion.

In order to set up a mutually convenient meeting time please ask Physician to contact Dr. Charles Dooley, SMRA Medical Director, at his office at 233-7878 by March 4, 1983. Usually, Wednesday afternoons appear to be convenient for most physicians.

Thank you for your continued cooperation.

Sincerely,

David Kaufman, M.D.
Chairman, Endoscopy Subcommittee

Charles E. Dooley, Jr., M.D.
Medical Director

cc: President of Medical Staff
Administrator

CONCURRENT REVIEW ACTIVITY SUMMARY

1. Acute Length of Stay

a. Medicare - The acute ALOS for Medicare patients for the period January through November 1982 was 11.3. For the year 1981, the acute ALOS was 11.9.

	Discharges	Acute Days	Acute ALOS
1981	25,895	308,608	11.9
1982	24,755	280,840	11.3

To date, this has resulted in an average reduction of 5%. For specifics, refer to Exhibit I.

b. Medicaid - Non-delegated review of Medicaid patients started with the admissions of February 1982. Available data show a reduction in ALOS of 6.9%.

	Discharges	Acute Days	Acute ALOS
1981	6,033	38,676	6.42
1982	5,455	32,618	5.98

For specifics, refer to Exhibit II.

c.*Blue Cross of New Jersey - The acute ALOS for Blue Cross of New Jersey patients for the period January through November 1982 was 5.6. For the third and fourth quarters of 1981, the acute ALOS was 6.0.

	Discharges	Acute Days	Acute ALOS
1981	11,191	67,478	6.0
1982	28,681	161,365	5.6

For specifics, refer to Exhibit III.

d.*Commercial/Other - The acute ALOS for Commercial/Other patients for the period January through November 1982 was 5.8. For the third and fourth quarters of 1981, the acute ALOS was 6.4.

	Discharges	Acute Days	Acute ALOS
1981	8,926	56,975	6.4
1982	26,202	152,385	5.8

For specifics, refer to Exhibit IV.

2. Monitoring - Formal and informal visits were conducted semi-annually at all seven acute-care hospitals. The areas monitored were:

- Concurrent review activities
- Appropriateness of Review Coordinator and Physician Advisor decisions
- Discharge planning activities
- Certification procedures
- Quality review studies
- Data quality and DRG validation

* Due to incompatible comparison data because of non-Federal phase-in, no days of care report is being noted at this time.

As a result of these visits, the SMRA de-delegated the Physician Advisor function of the review system at Hospital 605; and rescinded the probationary status for the Physician Advisor function at Hospitals 601 and 606.

3. DRG Appeals and Reconsiderations - January through December 1982

a. DRG Appeals

DRG Upheld	Reversed Charges	Rate Modified	Total Hearings
38	11	2	51

b. Reconsiderations

Hospital Decision Upheld	Hospital Decision Modified	Total No. Cases
18	7	25

ESSEX PHYSICIANS' REVIEW ORGANIZATION - ESSEX COUNTY URO

UTILIZATION REVIEW PROCESS UNDER CHAPTER 83, L. 78

I. 1982 UR Data

The table below displays EPRO's UR statistics from January through December, 1982 for Medicare and Non-Federal patients, and from March through August, 1982 for Medicaid patients (EPRO's non-delegated Medicaid review program was implemented on March 1, 1982).

PAY SOURCE	DISCHARGES	CERT DOC	CERT ALOS	TOTAL DOC	TOTAL ALOS	DENIALS
MEDICARE	35383	442009	12.5	471463	13.3	1350
MEDICAID	18598	112636	6.0	118788	6.3	980
NON-FEDERAL*	58513	375289	6.4	377386	6.5	443

* The Non-Federal data reported above reflects only those hospitals under DRG review prior to October 1, 1982 - 12 of the 16 Essex County acute care hospitals. Nine hospitals were implemented for DRG review in March, 1981, two hospitals were implemented in June, 1982 and one in July 1982. The remaining four hospitals were implemented after October 1, 1982.

II. Impact

A. Medicaid

EPRO reports a significant reduction in Medicaid discharges and days of care since the implementation of non-delegated review March 1, 1982. The display below clearly demonstrates the decreases in discharges, certified days of care, total days of care and costs per diem for the six month periods of March - August 1981 and 1982.

YEAR	DISCHARGES	CERT DOC	CERT ALOS	TOTAL DOC	TOTAL ALOS	DENIALS	TOTAL COST @$300/CERT DAY
1981	20343	123736	6.0	126597	6.2	350	$37,120,800
1982	18598	112636	6.0	118788	6.3	980	$33,790,800
CHANGE	-1745	-11100	-	-7809	+.1	+630	$-3,330,000

B. Medicare

A comparison of EPRO's UR data for Medicare appears below. The time periods being compared are January through September, 1981 and January through September, 1982.

YEAR	DISCHARGES	CERT DOC	CERT ALOS	TOTAL DOC	TOTAL ALOS	DENIALS
1981	34015	423199	12.4	454155	13.4	1342
1982	35383	442009	12.5	471463	13.3	1350

C. Non-Federal

A comparison of EPRO's UR data for Non-Federal patients appears below. The time periods being compared are March through September 1981 and March through September, 1982. Although only 9 of Essex County's 16 acute care hospitals are reflected in this display, it must be noted that these time periods were chosen as a basis for comparison because the nine hospitals were implemented for DRG review on March 1, 1981 while the other 7 hospitals were implemented sporadically as part of EPRO's "phase-in" plan for DRG implementation.

YEAR	DISCHARGES	CERT DOC	CERT ALOS	TOTAL DOC	TOTAL ALOS	DENIALS
1981	40876	249229	6.1	249854	6.1	183
1982	42333	267655	6.3	268734	6.4	231

D. Conclusion

EPRO's non-delegated Medicaid review program showed significant impact in 1982. Major reductions were reported in discharges, and certified and total days of care. As a result of these reductions, EPRO's non-delegated review program reports a savings of more than $ 3 million to Medicaid for the six month period studied.

Although the 1981/1982 statistics reported for Medicare do not show reductions in the UR categories displayed, the actual difference in numbers reported is insignificant. In 1982, EPRO maintained the proper utilization patterns set in 1981.

EPRO is not able to report any reductions in the 1982 statistics displayed for Non-Federal patients. However, the problem is being addressed and improvement in UR performance is anticipated in 1983.

III. AREAWIDE IPPB RESTUDY - IMPACT

Early in 1980, EPRO was invited to participate in a multi-PSRO study of IPPB Therapy coordinated by the Colonial Virginia Foundation for Medical Care. The purpose of this study was to determine actual practice patterns across PSROs in the treatment of diseases which could be more effectively or just as effectively treated with hand-held nebulizers, incentive spirometry and chest physiotherapy.

Thirty (30) PSROs participated in the original study representing 28 States, 502 hospitals and 21,477 patients. The data revealed that nationwide 58% of the cases studied did not meet the criterion for use and 40% of the cases did not meet the criterion for continued usage of IPPB.

Thirteen (13) Essex County hospitals participated in the original study which involved 432 cases. Essex County results revealed an excess number of orders for IPPB as well as prolonged duration of treatment based on predetermined criteria.

EPRO initiated a restudy of IPPB Therapy on June 23, 1982. Although two hospitals did not submit the necessary data in the original study and therefore were not represented in the comparison totals, there was a significant (68%) decline in the number of patients admitted and treatments administered for IPPB in January , 1982 vs. January, 1980. Conversely, there was a significant (52%) increase (comparing the same time frame) in the number of patients receiving incentive spirometry, indicating a trend away from IPPB toward other forms of respiratory therapy.

Comparison of data collected from respiratory therapy departments of the nine (9) hospitals also reflected significant impact.

One hospital with a 92% variation rate for Indications and a 100% variation rate for Duration of Treatment in the original study discontinued using IPPB Therapy as a result of findings from the original study. As a result of the restudy, another hospital stated that the use of IPPB Therapy would be phased out in the facility.

#/% Variations	Original	Restudy
Criterion I (Indication)	224/63	51/30
Criterion II(Duration)	214/60	50/29

Each of the nine Essex County hospitals participating in the restudy was asked to retrieve 25 patient records in which IPPB treatment was given with or without accompanying chest physiotherapy between January 1, 1982 and April 30, 1982. Records were chosen by random sampling, excluding patients under age 15. Two criteria from the original study were restudied: Indication for IPPB and Duration of Treatment.

It is estimated that the total cost savings realized by Essex County hospitals as a result of EPRO's IPPB Therapy study amounted to more than $94,500.

IV. DRG Appeals

In 1982, EPRO processed 295 appeals including 161 medical necessity appeals and 134 DRG-related appeals.

The activity can be summarized as follows:

•Medical Necessity Appeals

	TOTALS	UPHELD	REVERSED	MODIFIED
MEDICARE	30	14	11	5
MEDICAID	120	58	46	16
NON-FEDERAL	11	9	1	1

•DRG-Related Appeals

	TOTALS	UPHELD	CHANGED
DRG ASSIGNMENT	42	32	10
EQUITY	92	6	86

ESSEX PHYSICIANS' REVIEW ORGANIZATION, INC.
15 VILLAGE PLAZA, SOUTH ORANGE, NEW JERSEY 07079 • (201)763-8300

ACUTE MYOCARDIAL INFARCTION

STUDY SUMMARY NARRATIVE

Essex Physicians' Review Organization (PSRO Area IV) conducted its first AreaWide Medical Care Evaluation Study in 1978 with 12 hospitals participating.

Facilities with over 10,000 admissions per year were requested to retrieve 50 charts and those with under 10,000 admissions per year, 25 charts were requested. These charts were pulled consecutively starting from January 1, 1977 with the principal diagnosis of Acute Myocardial Infarction.

The total number of charts retrieved was 425 with 5 hospitals submitting 50 charts and 7 hospitals submitting 25. A total of 217 physicians managed these 425 patients.

The enclosed statistical analysis of the data collected reveals that the modal age was 65 and over in all cases except 1 hospital #103, in which case, it was between 50-64. 52.7% were over 65 years of age, 35.3% were between 50 and 64, 11.5% were between 35 and 49. Hospitals #107 and 115 accounted for the 2 patients between 20 and 34 with 0.5%.

As revealed in Table #2, the overall mortality rate was 25.2%, 20% occurring in the Intensive Coronary Units and 4.2% in the room. Out of a total of 425 patients, 107 died - 89 deaths in ICU and 18 in the room. Hospital #101 had the highest death rate of 38% and Hospital #110, no deaths. Further investigation was done in Hospital #110 which caused a delay in the final summary results. The next lowest death rate was 12% occurring in Hospital #116. Most of the deaths were justified by the Hospital Audit Committees. The highest ICU death rate was again in Hospital #101 with 30%, and the lowest in #116 with 8%. Hospitals #101, 117, 102, 103, 107, 111 and 115 had the highest death rate.

Analysis of the charts meeting the element in the 100% standard shows that the lowest compliance was in one specific area- namely, instructions to patients on discharge. Hospital #'s 111, 115, 113, 103 and 117 ranged between 92% and 86.6%. The lowest was Hospital #116, with 72.0%. The average % of cases meeting the 100% standard was 85%.

An enclosed explanatory guide for Tables #4 and 5 should be referred to when comparing these Tables.

. 16% of all charts met exception and critical management criteria.

Display graphs are shown for Tables #6, 7 and 8. Tables 6 and 7 show the comparative variation rates and #8 shows the average length of stay.

The Average Length of Stay on an overall basis was 16 days. The following tables show a breakdown of the ALOS in 3 different categories:

Under 14 days	ALOS = 6.0 days
Between 14-21 days	ALOS = 17.5 days.
Over 21 days	ALOS = 28.0 days

Total patients in study	- 425
Total patients days	6816
Average Length of Stay	- 16.0 days

It is important to note that confidentiality has been maintained throughout this project.

ESSEX PHYSICIANS' REVIEW ORGANIZATION, INC.
15 VILLAGE PLAZA, SOUTH ORANGE, NEW JERSEY 07079 • (201)763-8300
PSRO SUB AREA WIDE MCE STUDY #1/1978

"Acute Myocardial Infarction"

SUMMARY OF INFORMATION ITEMS

1. Total Hospitals Participating In Study ---------- 12
2. Total Patients In Study ---------- 425
3. Total Physicians In Study ---------- 217
4. Age Range of Patients ---------- (see Table #1)
5. Total Male Patients ---------- 289
6. Total Female Patients ---------- 136
7. Length of Stay (including Deaths) ---------- (see Table #8)
   - Total patients staying under 14 days -------- 117
   - Total patients staying over 21 days -------- 88
   - Total patients staying 14 - 21 days -------- 220
   - Total patients signing out AMA -------- 6
8. Deaths ---------- (see Table #2)
9. Percentage of cases Meeting the Criteria ----- (see Table #3)
10. Percentage of Variations/Justified ---------- (see Table #4)
11. Comparative Variation/Non Justified Rate ----- (see Table #5)
12. Comparative Variation Rate, Display (Pattern)-(see Table #6)
13. Percentage of Charts Meeting the Exception and Critical Management---------- (see Table #7)
14. Final Summary ---------- (see Table #9)

AREAWIDE TRANSFUSION STUDY
NARRATIVE SUMMARY

STUDY SPECIFICATIONS

The objectives of this study were:

1. To determine the appropriate utilization of blood and/or its components.
2. To determine if complications are properly managed.

The criteria used was generic in nature, therefore, all services, all ages and both sexes were included ir the study.

According to a hospital's total admissions, either 25 or 50 charts were used per hospital in the study. The hospitals' Committee Assistants were asked to use the first 25/50 consecutive cases starting June 30, 1979 back through July 1, 1978.

SPECIAL REPORTS

As a supplementary report to the audit, we asked the Committee Assistants to check the medical records and inquire at the Blood Bank as to the number of occasions on which blood was ordered but was not available. Unfortunately, only 6 hospitals were able to find any information regarding the availability of blood.

Special Report #1

3 occasions when documentation in the charts indicated that blood was not available.

2 occasions when blood was not available until the following day.

1 occasion when blood was not available for 3 hours.

Special Report #2

From July 1, 1978 through June 30, 1979, 5,697 units of blood were ordered and 5,150 units were given.

Special Report #3

One chart used in the study contained documentation that blood ordered was not available.

Special Report #4

No situation in which a patient was denied blood. However, there were occasions when there was a delay of one day in obtaining blood.

Special Report #5

Statistics are not kept. During critical shortages, physicians were requested to postpone elective surgery. This has ranged from several hours to a day. Blood has always been available for emergencies.

Special Report #6

This hospital's blood bank kept a tally for one month with the following results:

- Total amount of blood ordered 100 units
- Total amount of blood given 49 units
- Total amount of units ordered for which no blood was available. 45 units

ONE UNIT TRANSFUSIONS

In order to facilitate the computation of these transfusions, patients who received less than 1 unit, i.e., 40cc, were considered to have received one unit transfusions.

There were 93 patients who received one unit transfusions. Data retrieval by the Committee Assistants revealed that there were indications for 63 of the 93 transfusions. Only 50% of the remaining variations were justified.

CRITERIA VARIATIONS

There were 103 variations to criterion #1 which was the justification of the transfusions. Of the 103 variations, 63 were justified. This indicates that based upon available information

in the chart, 39% of the transfusions administered were unjustified. The majority of transfusions were indicated on the basis of a non-surgical condition associated with a hemoglobin of less than 8 grams.

Whole blood was administered to thirteen patients. 54% of these cases were not justified by the hospitals' audit committees.

There were 183 variations to criterion #3 which specified how the transfusion must be documented. Frequently, the transfusionist did not sign the transfusion slip. In some hospitals there is more than one place in the chart that the transfusionist must sign, however, in such cases only one area had a signature.

It was often difficult to determine if the number of units ordered equaled the number of units administered. This problem was chiefly attributed to nursing and as a result a few hospitals are planning process audits to investigate this problem further.

Very few variations were justified under criterion #4 - temperature taken pre and post transfusion.

There were 29 transfusion reactions noted in the study; 22 of these were justified. No expirations were attributed to transfusion reactions.

SUGGESTED FOLLOW-UP ACTIONS

1. Monitoring of indications for transfusions.
2. Monitoring the requests for whole blood.
3. Process audits on documentation of transfusions.
4. Development of a transfusion record for patients' charts on which the following information can be documented: patient's identity, # of units given, temperatures pre and post transfusion, dates, times and signatures.

STUDY SUMMARY NARRATIVE

EPRO AREAWIDE AMINOGLYCOSIDE STUDY

PART A (Tables #1-#3)

The purposes of Part A of the Aminoglycoside study were to 1) determine which antibiotics are used; 2) how extensively they are used; 3) which hospitals use them; and 4) the modes of administration.

There were 666 patients involved in Part A of the study; some of them received more than one antibiotic during their hospitalization.

The antibiotics are distributed by hospital in table #1. It is obvious from this display that the use of some antibiotics is limited to a particular hospital. Other antibiotics such as Keflex and Ampicillin are used extensively throughout the county.

In table #2, the data from each hospital is compiled to show every mode of administration used for each drug. Not all the antibiotics are listed here because some were given as drops, soaks or creams.

The total number of patients recorded next to each medication in table #3 is the total number of patients receiving that particular drug. Please keep in mind that some patients received more than 1 antibiotic, therefore making the total amount of patients receiving these drugs greater than the total number of patients in Part A of this study.

PART B (Tables #4-#7)

Table #4 is the criteria set used in the EPRO Areawide Aminoglycoside study. Please refer to this table when reviewing table #5. The aggegate data display, table #5, depicts the overall county performance in the study. Most variations occurred in criteria #IC4 and IC5. Many times the variations for these criteria were easily justified in light of the patients' conditions.

Upon data retrieval by the committee assistant, 346 patients of the 430 patients in the study were receiving aminoglycosides as indicated by the criteria. Of the 84 variations county-wide, 45 were justified after committee review. This means that 10.5% of the charts, had unjustified variations possibly indicating that aminoglycosides were inappropriately used.

Table #6 is a breakdown of ages by hospital. To make the age distribution more meaningful, we have made a special category for children under 1 year of age. The county-wide average age was 54.4. Table #6A is a graph displaying age by hospital using the average age for each hospital from table #6.

Although length of stay was not a criterion, it was felt that this item was important to investigate. The average length of stay for all hospitals was 28.6 days. Table #7 has a breakdown for length of stay in each hospital with total days used.

It is interesting to note the difference of total days used among hospitals using the same number of patients. There were 10,978 days used by the patients in this study.

If you require any assistance in the analysis of this data, please feel free to contact me.

As always, confidentiality has been maintained throughout this project.

SUBAREAWIDE

RE-AUDIT EKG INTERPRETATION STUDY

HOSPITAL ID #	# OF EKGs REVIEWED		EPRO AGREES WITH				EPRO DISAGREES WITH			
			AUDIT		RE-AUDIT		AUDIT		RE-AUDIT	
	AUDIT	RE-AUDIT	#	%	#	%	#	%	#	%
2	42	45	21	50	38	84	21	50	7	16
3	50	50	45	90	43	86	5	10	7	14
5	33	26	25	76	25	96	8	24	1	4
7	41	25	24	59	24	96	17	41	1	4
TOTALS	166	146	115	70	130	89	51	30	16	11

Excerpts from: *PSRO IMPACT ON MEDICAL CARE SERVICES: 1981*

(A Report of the 1981 Impact Committee - March 1982, American Association of Professional Standards Review Associations)

Alabama Medical Review, Inc., the PSRO for the entire state of Alabama, found unacceptably high acute myocardial infarction mortality rates in thirty hospitals in the state due to delays in placing patients on cardiac monitors and to delays in starting IVs. PSRO physicians met with their peers to discuss these problems and arranged for inservice training and continuing-medical-education efforts. A follow-up audit documented a 71% improvement in timely placement of patients on cardiac monitors and a 62% improvement in the expeditious administration of IVs.

The Central Piedmont PSRO, located in Durham, North Carolina, found that the mortality rate for acute myocardial infarction (AMI) patients in one hospital was 46.7%, a rate deemed much too high by the physicians. As a result, PSRO physicians met with their peers at that hospital, discussed the problems uncovered and arranged for medical education on AMIs. One year later, analyses showed that the mortality rate for AMI in that hospital had been reduced by 37%.

The Nassau Physicians Review Organization in Westbury, New York discovered one physician who, in the judgment of his peers, was providing poor-quality geriatric care. Physicians from the PSRO met with this physician to discuss problems and recommend necessary changes. Failure to correct the problems led to placing this physician on concurrent review and second-opinion consultation. Ultimately, the refusal of this physician to change his inappropriate practice patterns left his peers with no choice but to recommend to the Department of Health and Human Services that this physician be excluded from participation in the Medicare and Medicaid programs. A decision is still pending.

The Iowa Foundation for Medical Care found excessive inpatient dental extractions being performed. All physicians and hospitals involved received written correspondence documenting the problems. Pre-admission certification was implemented for dental extraction admissions. As a result, inpatient dental surgeries were reduced by 95%.

DRG VALIDATION COMPARISON

YEAR	HOSPITAL	CHANGED TO:
1982	LEFT ADNEXAL CYST DRG 319 $1,428.78	ABDOMINAL PAIN DRG 184 $ 900.20
1981	ACUTE MYOCARDIAL INFARCTION DRG 121 $6,672.50	CONGESTIVE HEART FAILURE DRG 132 $2,363.60
1981	HYPERTENSIVE HEART DISEASE DRG 119 $1,910.45	CONGESTIVE HEART FAILURE DRG 132 $2,363.60
1981	CLOSED HEAD INJURY DRG 356 $2,182.58	POST-CONCUSSION SYNDROME DRG 096 $2,400.12
1981	VIRAL PNEUMONIA DRG 168 $6,020.59	ASTHMATIC BRONCHITIS DRG 172 $ 980.89

ITEM 2. STATEMENT OF THE NATIONAL COUNCIL OF HEALTH CENTERS, WASHINGTON, D.C.

Mr. Chairman and members of the committee: The National Council of Health Centers appreciates the opportunity to submit this statement on the issues of quality assurance and prospective payment as they relate to skilled and intermediate nursing homes.

The membership of the National Council is comprised of multifacility nursing home firms who own or operate a total of 1,500 facilities in 48 States. Our members also provide many other services to the elderly such as meals-on-wheels, adult day care, home health, and retirement communities.

We appreciate the interest of the Senate Special Committee on Aging on the subjects of quality assurance and prospective payment, both of which are vital elements in an effective long-term care system.

Prospective payment and quality assurance are both crucial to the medicare and medicaid programs, the public, health facilities, and their patients. However, while essential to each other's success, they should be considered as separate entities in that quality assurance must be present in any payment system, regardless of whether it is retrospective or prospective.

Prospective payment, as the General Accounting Office pointed out in a recent letter to Senator Bob Packwood, is "more a concept than a system."[1] It involves setting a value on services to be provided so that the health provider knows in advance what the per diem rate will be and can then budget accordingly based on the patient needs.

Quality assurance is the determination that services provided to nursing home patients are appropriate to their needs and meet the Federal and State standards. This is a function which is the responsibility of the State, the Federal Government, and most importantly the nursing home itself.

Prospective Payment

For several years the National Council has been calling for a prospective payment system for the medicare skilled nursing benefit. It is our belief that medicare's retrospective payment system is inherently cost inflationary with no built-in incentives for efficiencies. The retroactive nature of the current payment system encourages providers to incur expenses and justify them later.

The vast majority of States already pay for their medicaid nursing home patients on some type of prospective system. These include payment by class of facility and/or service as well as payment by individual facility. The chief attraction for States to prospective payment methodologies has been the cost constraints that the States have been able to exercise over their expenditures under the medicaid program.

In describing the differences between the two concepts of payment, the GAO said: "Setting a rate in advance (prospective reimbursement) theoretically provides a health care provider the incentives to better plan and manage because it knows the amount it will receive and that it will suffer a loss if it exceeds that amount. Conversely, under a retrospective system, planning and management is said to be less important because final payment reflects the actual costs incurred with little consideration of whether the costs were incurred economically or efficiently."

There are many different approaches to prospective payment which may or may not fully address the financial needs of health facilities. It, however, should not be the purpose of a payment system to guarantee the financial success of a facility but rather to provide the opportunity for such success through effective management.

Audits

The financial audit process in a prospective system must be approached differently than in a retrospective system:

In the current medicare retrospective payment system, expenses in each cost center of each nursing home are reviewed after they are incurred. Allowable costs are identified and the rate, subject to a ceiling limitation, is established. The incentive is to spend more in the current year in order to increase the revenues to protect against the liability of retroactive adjustments to prior year payments.

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[1] General Accounting Office, letter to Senator Bob Packwood, May 10, 1982 (Information on Prospective Reimbursement Systems, GAO/HRD-82-73), see page 45 of this hearing.

For payment systems based on prospective rates, the clear incentive is for the provider to contain costs, and manage the facility's services efficiently while meeting the needs of the patients and the conditions of participation of the medicaid and medicare programs.

In short the former system requires the provider to spend while the latter requires the provider to manage.

For those States which pay on a prospective class rate basis, a facility by facility financial audit is time-consuming, expensive, and of questionable value. A much more cost-effective application of resources would result from a targeted audit of facilities within a percentage range of the class rate. The incurred expenses of nursing homes which comprise the midrange of expenditures are those which may determine the prospective year's rate in a class system and these are the facilities which the State needs to center its audit resources on. This format was strongly recommended by the GAO in its report "Audit of Medicaid Costs Reported by Autumn Hills Convalescent Centers, Inc., Houston, Texas" (GAO/HRD-83-9; October 14, 1982).

Assuring that the services provided meet the minimal Federal and State standards of care is not a function of the payment methodology. That responsibility falls to the Federal and State surveyors who inspect a facility for its compliance with the medicaid and medicare conditions of participation. It is essential for the financial audit and the facility survey function to be carried out successfully and independently in order for the total system to work.

Quality Assurance

As we stated earlier, the assurance of quality in nursing homes is a shared responsibility between the State, the Federal Government, and the nursing home. The actual role of the government entities is on of monitoring and enforcement. Primary responsibility for implementing a quality assurance program falls upon the nursing home.

Certainly there is no single best method to assure the quality of care. Among our multifacility members there are a number of successful approaches. Several of our members have established their own quality assurance team of surveyors which include medical doctors, nurses, pharmacists, dietitians, etc. There teams regularly inspect and monitor the nursing homes, subjecting them to the same type of rigorous inspections that Federal and State surveyors do.

One of our member firms in the Midwest has developed a problem-oriented approach to patient care wherein the emphasis is not on a particular patient's diagnosis, but rather on the set for problems his illness presents. Multidisciplinary teams of professional and nursing personnel determine the treatment regimen appropriate to each patient's problems, set goals for improvement, and regularly assess and evaluate the patient's progress.

A Tennessee-based member firm with 30 nursing homes has developed and implemented a sophisticated system of computerized patient assessment. This has been refined to a 1 page abstract which is completed for each patient on a monthly basis and upon significant changes in a patient's condition. The system costs about $1 per patient per month yet it permits the firm to accurately determine nursing and other staff needs. Equally important, each patient's treatment and progress is charted and monitored by nursing personnel and central office staff. The accumulation of such data over nearly 10 years' time permits the home office to profile patients by age, diagnosis, medications, and to track important indicators of patient care, such as the number of accidents, and the use of tranquilizers and restraints.

Another member firm has taken this process a step further by categorizing the various nursing services patients may need, assigning prospectively determined "management minutes" to each service. Each patient is assessed and charged a daily rate based on the amount of nursing care he or she needs.

The attractiveness in a system which pays according to nursing needs is its equity to the patient, payer, as well as the provider. This additionally could reduce the expensive hospital backlog of long-term care patients.

While National Council members have found that a quality assurance program is an essential and integral component of their operation, we are opposed to a mandate of one universal system or format defined in Federal statute or regulation. However, the incentive needs to be built into the system for a facility or firm to develop its own format that is most appropriate to its needs.

We invite your committee to review the various systems which are in place to see that there are many different, but nevertheless effective methods for assuring qual-

ity. We would be pleased to arrange meetings in Washington or on site at the nursing homes for you to see these various systems in operation.

A mandated assessment system is not a panacea and will not automatically change the quality of a nursing facility. Other external checks and balances are needed for monitoring and assuring the care in these facilities.

Survey Process

"We do not need more regulations, but rather better enforcement of existing regulations." This statement is reflective of the National Council's position as stated before congressional committees including this committee and to the Department of Health and Human Services over a number of years. We have also been generally supportive of the administration's effort to revise the survey process for all health providers. While the emotion of public attention has focused on the proposal to permit less than annual surveys, we would point out that the administration's intent was also to permit and encourage more frequent surveys for providers with repeated serious deficiencies.

On the submission of quarterly staffing reports, we stated in our testimony before this committee last year, we believed this requirement was little more than an exercise in paperwork and that the information is rarely examined or evaluated. We believe there are other more effective ways of assuring compliance with nurse staffing requirements.

In a real sense, the great majority of nursing homes are being penalized through excessive paperwork and regulatory requirements which have little, if any, positive impact on the quality of care being provided to our patients. No regulations or surveys can be an absolute guarantee against a breakdown in the system. However, fail-safe mechanisms can be designed in the system to detect and provide early warning to Federal and State agencies. Most importantly, serious deficiencies affecting direct patient care must be corrected immediately. Health facilities have a responsibility to their patients to provide the services that are needed, as determined by the attending physician, and this should not be compromised. At the same time surveyors have a critical job to perform in evaluating the facility's services and their compliance with Federal and State standards.

The National Council believes that a positive incentive-based compliance system, as is presently practiced in Massachusetts, could be the cornerstone to an effective survey system. The traditional reliance only on negative incentives has raised concerns that the imposition of fines and rate reductions may seriously affect the quality of care. While such fines may serve a purpose in isolated instances, we believe that a more universal level of success will be achieved by offering positive incentives.

Several years ago, in Massachusetts, a task force of representatives from the Rate Setting Commission, the Department of Public Health, the Department of Welfare, nursing home providers, and consumers, collaborated to develop a system to reward nursing homes which provide quality care. The task force developed a point system which was weighted to encourage improvements in nursing facilities and the care they delivered to their patients.

Under this positive incentive system, nursing homes which scored 95 percent or better received a 50-cent-per-patient-day bonus. Because of the weight placed on patient care improvements, nursing homes are encouraged to focus their resources and efforts on areas that directly benefit the patients. Financial incentives were also offered for accepting heavy care patients who were backed up in hospitals.

The success of this approach can best be demonstrated by the survey findings: In 1978, the program's first year, facilities compiled an average score of 86 percent; in 1979, the rate rose to 89 percent; and in 1980, the average was 91 percent.

In 1981, the program graded 536 facilities participating in the medicaid program. More than one-half scored 95 percent or better; the average score was 93 percent. Only 16 facilities were rated below 80 percent.

We strongly urge the examination and evaluation of this system as possibly one deserving of endorsement.

This is only one example of what can be accomplished in this area if the parties work cooperatively toward addressing the health care needs of the elderly. We would acknowledge the efforts of the Health Care Financing Administration and compliment its Administrator, Dr. Carolyne Davis, in establishing a process to accomplish that goal for the medicare program.

Mr. Chairman, in conclusion, we strongly support the development of a prospective payment system for medicare's skilled nursing facility services.

The fundamental principle of an effective payment system is the promotion of quality care at a reasonable cost to the purchaser. This can only be achieved if the health delivery system and the payment system are closely coordinated to attain a high degree of commonality of purpose. There are basically seven goals which the health delivery system and the payment system should share: (a) The establishment of quality levels of service. (B) The encouragement of efficiencies in the delivery of service. (C) The encouragement of the orderly growth. (D) Incentives for the patient to seek the most price competitive provider. (E) The opportunity for rewarding of provider efficiencies. (F) Administrative simplicity for third-party payers. (G) The opportunity for a profit for proprietary facilities and a capital allowance for nonproprietary providers.

Such a system will not inherently detract from the quality of such services, but rather if structured properly can enhance the quality of those services. Most importantly in an era of limited budgets it can assist in meeting the goal of providing quality care at a reasonable cost to the purchaser of that care. In the case of medicare skilled nursing services that purchaser, of course, is the Federal Government.

We appreciate this opportunity to submit our comments and look forward to discussing this issue with you, the committee members, and the committee staff.

ITEM 3. LETTER FROM SENATOR JOHN HEINZ, CHAIRMAN, SENATE SPECIAL COMMITTEE ON AGING, TO HON. RICHARD S. SCHWEIKER, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, DATED JANUARY 24, 1983, AND DRAFT COPY OF REPORT REQUESTED

Dear Mr. Secretary:

I would appreciate your assistance on a matter of some importance to the Senate Special Committee on Aging.

Over the last 15 years, the Aging Committee has conducted a series of investigations detailing problems in the operation of the Medicare and Medicaid programs. We have come to the conclusion that one of the fundamental problems in the Medicare system is its reliance on retroactive, cost-based reimbursement.

Repeatedly, members of the Committee have expressed desire to see this fundamental flaw remedied by the development of a prospective payment mechanism. We are pleased to see this desire reflected in the Medicare provisions of the TEFRA act passed last year and in the diagnosis related group payment mechanism developed by the Department in compliance with this act. I expect the Congress will give this proposal its early and thoughtful consideration.

In this connection, various elements of the media carried reports last November of a Region II evaluation of the DRG system employed in New Jersey. At that time, a member of my staff requested a copy of that report for the Committee's review. He was informed the report was not available because it was "full of errors" and had been returned to the region.

I can readily understand the Department's concern for the accuracy of the report. At the same time, I am concerned the Committee have an opportunity to evaluate all pertinent information when considering the DRG proposal. Accordingly, I would like to restate the Committee's interest in receiving a copy of the report in question. Please feel free to accompany the report with whatever disclaimers or corrective material you think would be helpful to the Committee.

Given the delay we have already experienced, I would appreciate it if you would expedite this request.

Sincerely,

JOHN HEINZ
Chairman

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I. EXECUTIVE SUMMARY

Working in conjunction with other Health Care Financing Administration components in the region, the Division of Quality Control (DQC) Region II examined the Professional Standards Review Organization (PSRO) monitoring and diagnosis related group (DRG) code assignment processes to determine how well those processes were working. This review included an assessment of three of the eight PSROs and 3 of 26 hospitals in New Jersey involved in the DRG project at the time.

In general, DQC reviewers found that the facilities reviewed were working within the framework of the ORD project design. However, some problems were found to exist with the program safeguards related to assigning correct DRG codes. In the study sample of 276 DRG cases, 28 or 10 percent contained an incorrect DRG code resulting in potential improper reimbursement. In 20 of the 28 cases, misassignment of DRG by the hospitals was contrary to State instructions involving the assignment of principal and secondary diagnoses.

It is recommended that the Office of Research and Demonstrations, the State of New Jersey and the PSROs collectively ensure that existing instructions which require the proper use of principal and secondary diagnoses are followed by the participating hospitals.

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New Jersey has designated the State's eight PSROs as Utilization Review Organizations (UROs) and made them responsible for assuring appropriateness of billings and codings. The study found that the lack of uniformity in URO monitoring sample size, frequency and lack of specific sampling of outlier cases did not assure the effectiveness of the monitoring program. We found that three PSROs had recommended changes in the DRG code assigned to 22 cases (from a study sample of 150), as a result of their monitoring activity; however, of the 17 the review team was able to verify, none were corrected. There is apparently no ongoing mechanism in the present system to assure that the changes PSROs recommend are, in fact, effectuated by the involved hospitals. (For 1982, the State plans to request all PSRO adjustments to the uniform bills in order to verify that the bills submitted to it were submitted correctly.)

We recommend that ORD instruct the State to establish guidelines for minimum or statistically valid DRG case sample size and frequency, with a focus on outlier cases. The guidelines should be coordinated with the fiscal intermediaries (FIs) in conjunction with their audit and monitoring responsibilities. Additionally, the State should assure that hospitals implement all PSRO recommended DRG code changes.

II. INTRODUCTION

In 1976, the Department of Health, Education and Welfare (now Health and Human Services - HHS) awarded a contract to the New Jersey State Department of Health

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to determine how well a hospital rate payment system based on diagnostic related groups would work. Using information on the lengths of stay as well as the costs of treatment at hospitals throughout New Jersey, Yale University, under contract to HHS, devised 83 broad categories and 383 specific or DRGs. Under the New Jersey system, hospitals are paid on the basis of diagnostic related groups (as opposed to the traditional retrospective cost basis), as long as the patient's length of stay falls within the assigned DRG's "trim points," i.e., the predetermined average length of stay at both the high and low end for each DRG code. If a stay is outside the trim points (either above or below), the claim is classified as an "outlier" and is paid on the basis of controlled charges which are adjusted to cost by the State at final reconciliation, pursuant to the State's Rate Setting Methodological Regulations.

In 1980, 26 hospitals began to receive payment on a fixed payment schedule based on type of case. An additional 40 hospitals were phased into the program in 1981. The remainder of the State's hospitals were phased in by the end of 1982. Recent refinements and changes in the coding system have resulted in expansion of the number of DRG categories from 383 to 467. It is important to note that at the time of our review, the State was still using the original 383 DRG codes.

Working in conjunction with other Health Care Financing Administration components in Region II, the Division of Quality Control examined the PSRO monitoring and hospital DRG code assignment processes to determine how well these processes were working. This review included evaluating three of eight PSROs and three of 26 hospitals in New Jersey in the DRG project at the time.

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To determine total payment for a particular DRG in New Jersey, DRG payment rates for direct patient care are multiplied by the expected number of cases within each DRG. These payments are then added to the reimbursable overhead costs, capital facility costs, outpatient costs and other items to arrive at a hospital's total payment. A hospital's case-mix for a given year is projected based on the actual case-mix of the base year, i.e., the experience of 2 years prior to the year in question (e.g., case-mix projections for 1980 were based on actual hospital experience in 1978). However, payment is based on the actual case-mix of the hospital during the rate year.

The PSROs in New Jersey have been designated by the State, through individual letters of agreement, to perform the utilization review function for the DRG project. Through a sampling of claims, the PSRO validates the accuracy of diagnostic codes assigned to each claim, making denials where appropriate and keeping beneficiary utilization statistics.

III. OBJECTIVES

The objectives of the study were to determine:

1. To what extent has misassignment of DRGs resulted in inappropriate billing practices which maximize reimbursement?

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2. To what extent are there effective safeguards within the New Jersey program to control misassignment of DRGs?

IV. SCOPE AND METHODOLOGY

The study was conducted from April 1982 through June 1982. A sample of three PSROs was selected for review. One PSRO covered a predominantly urban area, one an urban-suburban mix, and the third a suburban-rural mix. The PSROs represented central, southern and northern New Jersey. Within each PSRO area, one hospital was randomly selected for review using the following criteria: the hospital was among the original 26 phased into the DRG program in 1980 and had a substantial Medicare and/or Medicaid population; of the three, one was predominantly Medicare, one predominantly Medicaid and the third was an even mix.

Facility, PSRO and State/FI questionnaires were developed addressing hospital coding and billing procedures, PSRO oversight and monitoring protocols and State/FI and statistical experience to date. These review guides were designed to determine:

a. the accuracy and appropriateness of DRG assignment;

b. the incidence of outliers;

c. the adequacy of the PSRO oversight activity of the facilities; and

d. the adequacy of the State oversight activity of the PSROs.

Following visits to the PSROs to review their procedures and practices, the team met with administrative personnel at each facility to discuss the hospital's DRG assignment procedures and experience under the program and to select a sample of cases.

A valid statistical sample of 276 medical records was selected from the 3 facilities (93 at Hospital A, 109 at Hospital B and 74 at Hospital C). This provided for a 95 percent confidence level with a 5 percent tolerance. Only medical records for Medicare and Medicaid patients were selected randomly using a skip interval method for discharges occurring between October 1, 1981, and December 31, 1981. The cases were reviewed on-site by a nurse reviewer and a program analyst. DRG assignment was reviewed and, where discrepancies existed between the documentation in the medical record and the review staff's determinations, the record was duplicated and referred for review by a physician advisor who agreed with the findings of the program analyst and nurse reviewers in every case. The physician review addressed the appropriateness of DRG assignment.

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At the same time, billing data were collected with regard to outlier status, and comparisons were made to assess the impact of the outlier category on payments received by the hospitals.

Once the onsite activity was completed, State and FI personnel were interviewed with regard to the impact of the DRG program on reimbursement as well as their respective responsibilities with regard to the oversight and monitoring of the PSROs and facilities.

Finding 1

Under the New Jersey system, participating hospitals are reimbursed a predetermined amount based on the cost of inpatient care which in turn is related to the anticipated length of stay for each DRG. When a period of hospitalization falls outside this anticipated length of stay because it is shorter or longer than usual, an outlier case results, and the hospital is reimbursed according to charges adjusted to cost.

DRG hospitals are required to follow the New Jersey Administrative Code, Section 8:31 B-5, which governs DRG assignment and outliers, and contains definitions of principal and secondary diagnoses. The former relates to the patient's condition which caused the admission, as established after discharge; the latter relates to the patient's other conditions that existed at the time of admission or which developed

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subsequently and affected the treatment received and/or the length of stay. Section 8:31 5.1 B.ii specifically states "Diagnoses which have no bearing on the treatment received during a current hospital stay are inappropriate for use in DRG assignment."

In the study sample of 276 DRG cases, 28 or 10 percent appeared to be instances of DRG misassignment: 9 of 93 at Hospital A; 9 of 109 at Hospital B; and 10 of 74 at Hospital C. Fifteen of the 28 cases involved the incorrect use of DRG assignment, based on the use of secondary diagnoses in place of principal diagnoses. In 5 other cases, incorrect DRG assignments were based on secondary diagnoses which had no bearing on the treatment received during the hospital stay. The 8 remaining cases included 2 instances where surgery was included in the principal diagnoses but the surgery was either not performed or not reflected in the medical records; 4 cases involved the incorrect selection of the DRG code; 1 case where surgery was performed but not included in code because the physician incorrectly recorded the patient's diagnoses on the discharge record; and 1 case occurred where surgery was performed but was not included in the DRG code used. The entire sample was reviewed by a nurse reviewer; a physician advisor was given the questioned cases to evaluate. The physician advisor concurred with the RN reviewer in every case.

Among the 28 cases were 6 instances of DRGs billed as outliers. In 4 of the 6 outlier cases, the proper DRG assignment would have kept the stays within the established trim points and resulted in lower reimbursement based on the DRG formula rather than charges.

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A second sample of 43 cases which were part of PSRO monitoring was re-evaluated. Of the 319 cases in both samples, 64 were designated outliers by the 3 hospitals (54 of the 276 cases and 10 of the 43 cases were outliers). This represents 20 percent of the sample cases. Of the 64, fifty-one (82 percent) exceeded the trim points on the high side. When the New Jersey demonstration project was initiated, a projection of 2 percent outlier cases was made.

Statistical data published by the New Jersey Hospital Association (NJHA) indicates that the percentage of outlier cases rose to 20 percent in 1981 from 3 percent in 1980. The direct patient care costs of outlier cases increased from an average of 9 percent of the DRG cases in 1980 to an average of 30 percent in 1981. The cause for the rise is attributed by the State to their own refinements of trim points for DRGs which have narrowed the high-low range. While these refinements have made DRGs more statistically homogeneous, more outliers have been created.

Some examples of DRG misassignment from the study follow:

1. At Hospital A, there was a case where a patient was admitted for an intracapsular lens extraction. The patient had hypertension and the case should have been billed at DRG 110, Disease of The Eye With Surgical Procedure, but was billed at DRG 117, Hypertensive Heart Disease With Minor Secondary Diagnosis. Payment for DRG 117 was $2,362; payment for DRG 110 would have been $1,623.

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2. A case at Hospital B involved a patient whose stay was classified as DRG 203, Abdominal Hernia, for which the hospital was reimbursed $4,215. The PSRO physician advisor determined that the case should have been billed DRG 333, Chemical Imbalance, for which reimbursement would have been $1,931.

3. A case at Hospital C involved a patient whose stay was billed at DRG 340, Fracture Without Surgery. Although the patient had been treated for a fracture of the second lumbar during a prior hospitalization, the hospitalization reviewed was for Acute Gastritis, DRG 188. DRG 340 paid $1,667; DRG 188 would have paid $1,177.

4. At Hospital B, there was a case of a patient staying 18 days under DRG classification 060, Benign Tumor of the Intestines, Without Surgery. The trim points for this DRG in New Jersey are 2 to 12 days. As an outlier, the case was billed and paid based on charges of $8,671. However, medical reevaluation of the case indicated it would have been more appropriately billed under DRG classification 132, Disease of the Heart, Without Surgery. As a result, it would not have been an outlier case. The trim points for DRG 132 are 3 to 24 days, and would have been reimbursed at a cost of $2,967.

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Sample size for PSRO monitoring has not been specified by the State, nor is it addressed in DRG-related regulations. As a result, PSRO monitoring is not uniform. PSRO retrospective monitoring of DRG cases throughout the State consists of an approximately 1.5 percent sample. At the 3 study hospitals, sampling size has been 1 percent by 2 PSROs and 3 percent by the third. The refinement of trim points for DRGs created more outliers than the original 2 percent, but there has been no corresponding refinement in PSRO monitoring to deal with the increase. Outlier cases were picked up randomly within the sample.

The misassignment of 20 DRGs among the 28 found in the study (70 percent) resulted from DRG assignments by the 3 hospitals which were contrary to State regulation requirements involving principal and secondary diagnoses. The 28 cases of misassigned DRGs resulted in greater payments to the study hospitals than warranted. Where utilization review of Medicare cases is delegated to the hospitals, the PSROs have no direct oversight of the DRG assignment. Thus, instances of DRG misassignment can only be found during the PSRO monitoring process or by the fiscal intermediary. The small monitoring samples reviewed by PSROs have apparently not provided the best opportunity for discovering instances of DRG misassignments and inappropriately designated outlier cases. Only PSRO C was able to provide the review team with the total percentage of cases billed as outliers.

RECOMMENDATION

HCFA's Office of Research and Demonstrations (ORD) should instruct the State of New Jersey to assure that requirements stipulated in Section 8:31B-5.1 of the New Jersey Administrative Code are properly implemented. ORD should also direct the State of New Jersey to consider focusing more attention on the selection for PSRO monitoring giving special attention to outlier cases.

Finding 2

As part of this study, the review team evaluated the PSRO retrospective monitoring activities of DRG cases at Hospitals A, B and C for the period July 1981 to January 1982. The monitoring included Federal (Medicare and Medicaid) and private patient DRG cases.

PSRO A, which monitors on an annual basis, reviewed 40 cases at Hospital A for DRG assignment and disagreed with 6 of the 40 cases. PSRO B, monitoring every 6-8 weeks, looked at 10 DRG cases at Hospital B and agreed with all 10 cases. PSRO C, utilizing semi-annual monitoring, reviewed 100 DRG cases, disagreeing with 16 cases. Of the 22 cases with which PSROs A and C disagreed, 18 involved the improper use of secondary diagnoses for the DRG designation.

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The New Jersey Administrative Code, Section 8:31 B-3.79 states that: "the qualifying utilization review organization shall direct the hospital and the Uniform Bill Intermediary to make an appropriate adjustment to the price per case where the DRG to which the patient is correctly assigned differs from the DRG on which payment was based."

Although the PSROs found DRG discrepancies and notified facilities as to improper DRG assignment, there is no on-going system in place to assure that once the hospital has been notified of coding errors, this information is sent on to the State and FIs in the form of corrected bills. When the review team followed up with the FI to determine whether corrected bills were submitted by the hospitals for the 22 sample cases, it was learned that in 17 instances (9 Medicare, 2 Medicaid and 6 private plan) none had been submitted. Information on the remaining 5 cases was not as yet available to the review team. (For 1982 the State plans to request all PSRO adjustments to the uniform bills in order to verify that the bills submitted to it were submitted correctly).

The study hospitals failed to correct billing in those sample cases where the PSROs disagreed with the DRG assignment. PSRO retrospective utilization review determinations, which change the original DRG assignment, affect the DRG case-mix statistical data influencing prospective DRG rates.

RECOMMENDATION

HCFA's Office of Research and Demonstrations should direct the State of New Jersey to implement a mechanism within the DRG system to assure the correction of DRG hospital billing required by PSRO retrospective review determinations.

ITEM 4. LETTER FROM SENATOR JOHN HEINZ, CHAIRMAN, SENATE SPECIAL COMMITTEE ON AGING, TO CAROLYN D. DAVIS, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, DATED FEBRUARY 24, 1983

Dear Dr. Davis:

On behalf of the Senate Aging Committee, I would like to again thank you for your excellent testimony at the Committee's February 4, 1983 hearing. From your statement, it is clear we share a desire to move from the current Medicare payment system to a prospective mechanism that encourages efficiency and quality with incentives and restraining costs.

In this regard, I would appreciate your response to the questions listed below for the hearing record. Most of these questions arise from the Toby memorandum we discussed at the hearing. I believe it is essential that these concerns be addressed to the extent they are valid and relevant to the DRG proposal submitted to Congress by the Department. To the extent these concerns are invalid, I believe it is equally important that the record reflect this fact.

1. In my January 24, 1983 letter to Secretary Schwieker concerning the Region II validation, I requested a copy of the validation and "whatever disclaimers or corrective material" the Administration thought would be helpful to the Committee. I subsequently obtained a copy of the draft validation from your office and a copy of Mr. Tobey's memorandum from other sources. I would appreciate a copy of your response to Mr. Toby and any subsequent related correspondence from or to Mr. Toby on this issue.

2. I am particularly concerned with Mr. Tobey's statement that the system generated windfall profits for some providers. What has been the financial impact of the DRG system on Medicare reimbursement in New Jersey from the inception of the experiment to the present? Please respond by year, total dollar difference and percentage.

3. Toby indicated, based on an analysis of unaudited 1981 Medicare cost reports of 41 DRG hospitals that DRG reimbursement exceeded Medicare costs by more that $31 million. Have windfall profits been generated in New Jersey? To what extent were these excess, if any, anticipated? What is being done to prevent these kinds of windfall profits in a national DRG system?

4. Mr. Toby expressed what appears to be a generic concern that prospective systems create incentives to manipulate admissions, discharges and ancillaries in order to maximize reimbursement. To what extent are these concerns valid? How will these problems be addressed by the Administration's proposal?

5. Mr. Toby expressed a belief that systems such as those employed in New Jersey require the development of focused quality assuance programs. Do you agree? If so, how will this need be addressed by the Administration's proposal, particularly in light of the related proposal to defund PRO/PSROs?

Sincerely,

JOHN HEINZ
Chairman

JH/bhh

ITEM 5. LETTER FROM RICHARD L. FOGEL, DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, TO SENATOR JOHN HEINZ, CHAIRMAN, SPECIAL COMMITTEE ON AGING, DATED JUNE 15, 1983

Dear Mr. Chairman:

Subject: Comments on a Health Care Financing Administration Regional Office Report on New Jersey's Diagnostic Related Group Prospective Reimbursement Experiment (GAO/HRD-83-63)

Your February 17, 1983, letter forwarded a copy of a report by the Health Care Financing Administration's (HCFA's) New York Regional Office on New Jersey's Diagnostic Related Group (DRG) hospital prospective payment experiment. Your letter states that the New Jersey system has had an unanticipated impact on reimbursement, produced an unexpected administrative burden, altered and increased the need for utilization review and financial audits, and required a lengthy implementation process. You asked us to comment on the report's findings and recommendations and to assess their relevance to the administration's proposed Medicare hospital prospective payment system. A Medicare prospective payment system that differs in several important ways from the administration's proposal was recently enacted into law. (Social Security Amendments of 1983, Public Law 98-21, Apr. 20, 1983.)

The administration's proposed bill was very general and would have granted the Secretary of the Department of Health and Human Services (HHS) broad authority to design, implement, and operate the system. Therefore, whether the proposal, if enacted, would have addressed the problems discussed in the HCFA Regional Office report would have depended largely on actions taken by HHS in establishing and operating the payment system. The Congress included features in Public Law 98-21 which attempt to address concerns like those expressed in the HCFA Regional Office report.

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BACKGROUND

Medicare generally pays hospitals on a reasonable cost basis; that is, hospitals are paid their actual costs of providing patient care as long as costs meet Medicare's definitions of allowability and reasonableness, and as long as they neither exceed 120 percent[1] of the average costs per discharge of comparable hospitals nor increase from prior costs per discharge by more than an annually fixed percentage.[2] During fiscal year 1982, Medicare paid over $32 billion to hospitals, and such expenditures have increased an average of 19 percent per year since 1979. While the general rate of inflation as measured by the Consumer Price Index slowed to 3.9 percent in 1982, hospital costs rose 12.6 percent under this index.

The Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248, approved September 3, 1982, required HHS to submit a report to the Congress about a potential prospective payment system for hospitals and other providers. Under a prospective system providers are told in advance what they will be paid and normally the payment level is not retrospectively adjusted to reflect actual costs.

In a December 1982 report, HHS recommended to the Congress a hospital prospective payment system for Medicare covering routine and ancillary service costs and submitted proposed legislation on February 22, 1983, to implement this system. The proposal provided for payments based on the patient's diagnosis. The DRGs to be used were developed by Yale University, which grouped diagnoses by physiological system and severity of illness. The grouping of diagnoses was designed to include those cases which are closely related in the extent of resources expected to be devoted to treating the patients.

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[1]For hospital cost report years ending in fiscal year 1983. For reporting years ending in fiscal years 1984 and 1985, this percentage was scheduled to decrease to 115 and 110 percent, respectively. However, Public Law 98-21 makes this reimbursement limit inapplicable after fiscal year 1983.

[2]The allowable increase is defined as the percentage increase in an economic index designed to reflect changes in hospital operating costs plus 1 percent. This limit acts as an upper limit on payments for fiscal years 1984-86 under the revised reimbursement system in Public Law 98-21.

The amount Medicare would pay would be the national average Medicare cost per discharge, adjusted for local wages, for the DRG into which the patient's diagnosis falls. Although not specifically stated in the administration's proposed legislation, HHS' report to the Congress indicates that capital and education costs would continue to be reimbursed on a reasonable cost basis. The rates paid by Medicare would be payment in full to the hospital which could not charge the beneficiary except for Medicare's coinsurance and deductibles for inpatient hospital services.

The administration's proposal provided for an annual adjustment of the fiscal year 1984 payment rate, but was not specific about how payment levels would be adjusted in the future. It did state that payment levels were to be updated periodically and that HHS could consider such factors as the increase in the costs of goods and services purchased by hospitals, improved hospital industry productivity, and technological changes.

The Congress, in enacting Public Law 98-21, adopted a prospective payment system based on DRGs which substantially modified the administration's proposal. The legislation requires the Secretary of HHS to develop a national and nine regional DRG rates, each having an urban and rural rate adjusted for local wages. The prospective payment system would be phased in over a 3-year period. Generally, the amount each hospital would be paid is based on a proportion of the national and regional payment rate and a portion based on the costs incurred by the hospital.[3] The prospective payment rate applies to hospitals located in the 50 States and the District of Columbia except for psychiatric, rehabilitation, children, or long-term care hospitals, or a distinct psychiatric or rehabilitation unit in a hospital. Capital and educational expenses would be paid on a cost basis, but HHS is to report to the Congress by October 1984 on a suggested method for including capital costs in the prospective payment rates.

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[3]The DRG prospective payment rate would be phased in as follows.

Fiscal year	Percent of payment to hospital based on Cost	Census Region DRG rates	National DRG rates
1984	75	25.0	0
1985	50	37.5	12.5
1986	25	37.5	37.5
1987	0	0	100.0

The law requires the Secretary of HHS to adjust the DRG payment rates each year and to make other adjustments as necessary. To assist the Secretary in adjusting the DRG rates a Commission was created to review the use of new technologies and treatment modalities and to recommend changes to the rates based on its evaluation.

ISSUES REPORTED BY HCFA'S NEW YORK REGIONAL OFFICE ON NEW JERSEY'S PROSPECTIVE PAYMENT SYSTEM

A prototype DRG-based prospective payment system was developed in New Jersey under a $5.3 million grant from HCFA. The New Jersey system was phased in over several years beginning with 26 hospitals in 1980. As of December 1, 1982, New Jersey's system covered 99 acute care general hospitals and applied to all payors. To obtain uniform data on which to set prospective rates, New Jersey required hospitals, beginning in 1975, to file uniform cost reports. Thus, the first step for most New Jersey hospitals was developing a substantial data base that incorporated financial data and clinical information. Reportedly, considerable resources were expended to improve hospital medical record departments to support each hospital's data base and to help assure the accuracy of DRGs assigned to patients for payment purposes.

HCFA's New York Regional Office prepared a report (dated Aug. 9, 1982) on New Jersey's prospective payment experiment which identified issues the Office believed should be addressed by any proposal for a national DRG prospective payment plan. HCFA headquarters staff reviewed the Regional Office report and advised the Regional Office in October 1982 that a complete evaluation of the New Jersey experiment is scheduled to begin after its completion in December 1983.

The observations and recommendations made by the HCFA Regional Office related to two main areas:

--The need for a utilization review mechanism to assure quality of care and accurate reporting of diagnoses for payment purposes.

--Suggested modifications to New Jersey's payment system if it were to be used nationwide.

These areas are discussed in the following sections.

Utilization review mechanism needed

The HCFA New York Regional Office noted three areas where potential problems could arise that indicated the need for a reliable utilization review mechanism. The first of these was the potential for hospitals to manipulate diagnosis reporting in order to maximize Medicare payments under a DRG system. The Regional Office report noted two studies which indicated the potential for hospitals to maximize payments by reporting high paying diagnoses or combinations of diagnoses.

A study conducted by the University of California at San Francisco Department of Medicine showed that, by reporting for payment purposes as the principal diagnosis the higher paying of either the principal or secondary diagnosis, the University's hospital would have received 14 percent more in 1978 if it were under a DRG payment system similar to New Jersey's. A computer program was designed which selected automatically the sequencing of diagnoses that ensured maximum payment. In 23 percent of the cases, reporting the actual secondary diagnosis as the principal diagnosis for billing purposes would have increased the DRG payment.

The HCFA New York Regional Office also conducted a study to determine the accuracy of diagnosis reporting at selected New Jersey hospitals. The results reported were:

--Review of a sample of 276 Medicare and Medicaid claims from three hospitals indicated that 28 (10 percent) of the claims appeared to have inappropriate DRGs. The billed DRG in all 28 cases resulted in higher payments than would have been obtained using the DRGs the Regional Office believed were appropriate.

--The Regional Office looked at the Professional Standards Review Organizations' (PSROs')[4] retrospectively monitored claims from the same three hospitals. The PSROs

[4]PSROs are responsible for making medical necessity and appropriateness determinations for Medicare inpatient hospital services and can perform this function for Medicaid at each State's option. The Tax Equity and Fiscal Responsibility Act of 1982 replaced the PSRO program (effective Oct. 1, 1983) with the Utilization and Quality Control Peer Review Organization Program (referred to as PRO). The PROs would have similar responsibilities to those of the PSROs for Medicare and could carry out utilization review functions for other payors.

reviewed a sample totaling 150 claims (all payors) and disagreed with the DRGs reported by the hospitals in 22 cases (15 percent).

The second area of potential problems noted by the Regional Office indicating a need for utilization review involved assuring appropriate utilization of services and quality of care. The Regional Office pointed out that a DRG-based prospective payment system introduces a new incentive to hospitals, namely providing the least costly care to patients by avoiding unnecessary care. This incentive carried to the extreme could result in adverse impacts on quality of care. Possible examples cited in the report included manipulating ancillary services and premature discharges to minimize costs and increasing admissions to maximize payments. The Regional Office believed that, if any of these actions occurred, quality of care could be adversely impacted.

The third area of potential problems related to DRG outliers which are cases where the patients' length of stay or other factors differ substantially from the norm for the DRG involved. The Regional Office was concerned about the percent of cases falling into the outlier category in New Jersey--an estimated 30 to 35 percent of all inpatient cases in 1982 were expected to be outliers. The Regional Office believed monitoring of outlier cases was needed because of the significant impact on payments these cases have because hospitals receive additional payments for such cases.

Based on these observations the Regional Office recommended that

--hospitals be given very specific instructions on diagnoses designation and sequencing and that review of this area be emphasized,

--a more innovative approach to utilization review and quality assurance than that used in New Jersey be adopted, and

--a monitoring system for outliers be established to minimize the number of cases falling into this category or alternately paying outliers on a cost rather than a charge basis.

In a recent report[5] we expressed similar concerns about the potential problems that could arise under a DRG-based prospective payment system and the need to have a utilization review mechanism to control abuse. We stated that the administration's proposed DRG prospective payment system included provisions which could (1) allow for manipulating admissions and diagnostic coding to increase total reimbursement and (2) result in adverse impacts on the quality of care provided to Medicare beneficiaries. Therefore, it is necessary to maintain a PSRO/PRO type function at least until it can be demonstrated that these potential problems do not arise under the proposed hospital payment system. In addition, we noted several instances in the December 1982 HHS report to the Congress on the proposed prospective payment system which identified potential problems and which we believe pointed out the need for a PSRO/PRO type function. These areas included:

--The proposed system might encourage hospitals to release patients prematurely which in turn might result in otherwise unnecessary readmissions and a second payment.

--The proposed system might encourage hospitals to transfer unnecessarily a patient to another provider or to reduce the provision of important ancillary services to minimize costs.

--There is an incentive in the proposed system for unnecessary admissions.

--There is an incentive under the proposed system for hospitals to report higher level diagnoses in order to obtain higher payments.

The administration proposed eliminating both the PSRO program and the requirement that hospitals not covered by a PSRO establish utilization review committees. Also, the President's budget for fiscal year 1984 does not provide any funds for a PRO program. Thus, there would not have been a required program of physician review of the medical necessity and appropriateness of inpatient hospital services under Medicare.

The administration's proposed legislation for a DRG prospective payment system did not address the mechanisms to be used to control against the problem areas raised by HCFA's New

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[5]"GAO Staff Views on the President's Fiscal Year 1984 Budget Proposals" (GAO/OPP-83-1, Mar. 4, 1983), pages 69-72.

York Regional Office, by HHS' report to the Congress on the proposed prospective system, and by us in our March 4, 1983, report. However, the Congress in enacting Public Law 98-21 addressed these concerns. The law requires hospitals to contract with the PRO covering its area, if one has been designated, by October 1, 1983, in order to receive Medicare payments. If a PRO had not been designated for a hospital's area by October 1, 1984, the hospital could not receive payments from Medicare. PROs are to review (1) the validity of diagnostic information provided by hospitals; (2) completeness, adequacy, and quality of care provided; (3) appropriateness of admissions and discharges; and (4) appropriateness of care for outlier cases. If the PRO program is implemented (required under Public Law 97-248 on Oct. 1, 1983) and PROs are effectively performing the functions listed above, the concerns expressed by HCFA's New York Regional Office and by us should be addressed.

Suggested modifications to New Jersey's payment system if it applied nationwide

The HCFA New York Regional Office report made suggestions for modifications to New Jersey's DRG payment system if it was to be applied nationwide. The suggestions fell into four areas: (1) treatment of bad debts, (2) appeals for changes in reimbursement, (3) payments for outliers, and (4) the need for cost reports and audits of them.

The Regional Office was concerned about the impact that including a factor in payments to cover hospitals' bad debts could have on payments and how changing economic conditions could affect the level of bad debts. Under Medicare's cost reimbursement system, the only bad debts recognized as costs were those directly related to Medicare patients; that is, unpaid Medicare deductible and coinsurance amounts. The prospective payment system enacted by the Congress continues Medicare's prior policy on bad debts, so we believe they should not significantly affect the new payment system.

The Regional Office was also concerned about the number of payment rate appeals occurring under New Jersey's system because most providers covered by it in 1981 appealed their initially set rates. While New Jersey's rate-setting system involved a number of steps which could result in appeals of payment rates, the Medicare DRG payment system enacted by the Congress does not permit appeal of the payment rates. Thus, the concerns of the Regional Office about the administrative burden of payment rate appeals should not be as significant a problem under Medicare's revised hospital payment system.

Regarding payments for outlier cases, the Regional Office made two recommendations that

--the number of cases falling in the outlier category be held to a minimum (it was expected that 30 to 35 percent of the cases in New Jersey would be classified as outliers) or

--outlier cases be paid on the basis of costs rather than hospital charges as was done in New Jersey because charges normally exceed costs and paying charges would increase Medicare payments.

The administration proposed that only cases which exceeded a DRG's average length of stay by 30 days or more be classified as outliers; discharges with very short lengths of stay would be paid the DRG rate.[6] This was expected to result in about one-half of 1 percent of the cases falling in the outlier category.

The law as enacted requires that additional payments for outlier cases be not less than 5 percent nor more than 6 percent of total DRG payments.[7] Therefore, outlier payments are supposed to be held, under Medicare's system, to a percentage substantially below that experienced in New Jersey.

The administration's proposed legislation did not state how additional payments for outlier cases would be calculated. The law as enacted does not state how such payments are to be calculated, but does provide that they shall approximate the marginal cost of care beyond the point which makes the case fall into the outlier category. We are concerned that hospitals not be able to increase payments by keeping patients longer than necessary

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[6]New Jersey uses a relatively complex system to classify outliers under which meeting any of seven criteria puts a case in the outlier category. Cases are classified as outliers if, for example, they significantly vary from the average length of stay on either the high or low side.

[7]The conference report (H. Rept. No. 98-47) on Public Law 98-21 stated that the conferees were equally concerned that adjustments may be required for cases which have an unusually short length of stay or which are significantly less costly than the DRG payment. The Secretary of HHS is required to report in the annual report on the prospective system on how to address such low cost cases.

in order to receive an outlier payment. If hospitals only receive, as an outlier payment, the additional costs directly related to care provided after a case reaches the outlier cutoff point--that is, marginal costs--as required by the law, this should not provide an incentive to retain patients longer than necessary or enable hospitals to gain from outlier cases.

Finally, regarding the need for cost reports and audits of them, the Regional Office expressed its concerns that Medicare payments under the New Jersey DRG system had exceeded the amounts that would have been paid under Medicare's cost reimbursement system. The Regional Office stated that it had anticipated that payments would increase and that the percentage increase might not be excessive considering that payments included a factor for uncompensated care (bad debts) and that the payment methodology had changed. However, the Regional Office was concerned that the two hospital cost report audits which had been done indicated that at least initially the New Jersey system may be quite costly. The Regional Office said it was developing an audit program so that HCFA could be furnished hard data on such things as actual costs, cost shifting, and data collection. The Regional Office was also concerned about whether sufficient funds would be provided to carry out the audit program. It recommended that the need for auditing and commitment of funds be built into the design of any new national DRG prospective payment system.

As we have stated in the past,[8] we believe that prospective payment systems should be based on the costs which would be incurred by an efficient and economical provider to deliver needed care. For the Medicaid program, the Congress has required the States to have reimbursement systems for hospitals and nursing homes which meet similar requirements. We also believe that to determine the cost level at which efficient and economical providers can deliver needed services and to ascertain changes in this level over time, it is necessary to obtain, through audited cost reports, data on actual reasonable and allowable costs incurred by at least a statistically reliable sample of providers.

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[8]For example, see "Information on Prospective Reimbursement Systems" (GAO/HRD-82-73, May 10, 1982) and testimony before the Subcommittee on Health, Senate Committee on Finance, on the data used by HCFA in preparing its proposal to establish a prospective reimbursement system for the End-Stage Renal Disease Program, March 15, 1982.

During the hearings on the bills which eventually resulted in the enacted DRG prospective payment system, concerns about the accuracy of the data bases which will be used to set the DRG payment rates were expressed. Public Law 98-21 requires hospitals to continue submitting cost reports through fiscal year 1988. Also, during fiscal years 1984-86, hospitals will continue to be paid by Medicare partially on a cost basis so auditing of cost reports should continue. In addition, Public Law 97-248 authorized an additional $45 million per year during fiscal years 1983-85 for Medicare claims paying agents to be used exclusively for cost report auditing and medical reviews ($23 million of the $45 million appropriated for fiscal year 1983 has been allocated to cost report auditing).

Finally, Public Law 98-21 requires that payments to hospitals not exceed what would have been paid under the reimbursement system in existence before the revised system for fiscal years 1984 and 1985; that is, the rate of increase limit on payment per discharge established by Public Law 97-248 (see p. 2). Therefore, the tools (cost reports) shall be available to determine the impact the revised system has on hospital costs in such areas as those raised by the Regional Office. Also, cost report auditing should continue to be performed and funds should be made available for this purpose. In addition, the utilization review program which the Congress mandated for the DRG system should provide the information needed by the Government to address many of the questions raised about the current data bases and to help assure that DRG payment rates accurately reflect the costs which would be incurred by efficient and economical providers to furnish needed service. Thus, assuming that the utilization review program is effectively implemented and that costs reports are adequately audited, the Government should, in the future, have better data bases on which to establish prospective DRG payment rates.

OBJECTIVE, SCOPE, AND METHODOLOGY

The objective of our review was to address the concerns expressed by HCFA's New York Regional Office in a report regarding its experience with the DRG experiment in New Jersey in view of (1) the prospective system proposed by the administration for Medicare and (2) the prospective payment system enacted into law. We interviewed knowledgeable officials, including New Jersey State officials responsible for operating, monitoring, and evaluating the New Jersey program. We interviewed HCFA officials both in the New York Regional Office and at headquarters. Also, we talked with a consultant doing work on the New Jersey program and an intermediary responsible for New Jersey

hospitals in order to evaluate the recommendations made by HCFA's New York Regional Office. In addition, we reviewed articles in medical publications specifically dealing with utilization of hospital services and the New Jersey experiment. We also reviewed the administration's report to the Congress, congressional committee and conference reports, and the Social Security Amendments of 1983, Public Law 98-21, to determine whether the law addressed the concerns of HCFA's Regional Office. As requested by your office, we did not obtain comments from HHS on this report.

Except as noted above our work was done in accordance with generally accepted government audit standards.

Unless you publicly announce its contents earlier, no further distribution of this report will be made for 21 days. At that time, we will send copies to interested parties and make copies available to others upon request.

Sincerely yours,

Richard L. Fogel

Richard L. Fogel
Director

ITEM 6 2-17-81

Texas Department of Human Resources

John H. Reagan Building, Austin, Texas 78701

JEROME CHAPMAN
Commissioner

BOARD MEMBERS
HILMAR G. MOORE
Chairman, Richmond
RAUL JIMENEZ
San Antonio
Wm TERRY BRAY
Austin

AGENDA

Texas Board of Human Resources
706 Banister Lane
Austin, Texas
February 26, 1981
10 a.m.

1. Approval of Minutes of January 15 and 16, and February 13, 1981.
2. Recognition of employees.
3. Purchased Health Services contract.
4. Appeal from audit exceptions involving Colonial Gables Nursing Home and Colonial Manor Nursing Home.
5. Community MH/MR centers' clinic services under Titles XIX and XX.
6. Adjustments to FY 1981 operating budget.
7. Adjustment of rates for primary home care.
8. Rate methodology for Intermediate Care of the Mentally Retarded.
9. Policy changes in the Aid to Families with Dependent Children program.
10. Policy changes in eligibility criteria for the Nursing Home program.
11. Mid-year review of nursing homes reimbursement.
12. Policy on statewide mail issuance of food stamps.
13. Drug destruction study.
14. Legislative matters.
15. Final rules:
    a. Food stamps basis-of-issuance tables.
    b. Records management.
    c. Protective payee procedures.
16. Technical amendments to program policies and procedures.
17. Commissioner's report.
18. Executive session on personnel matters, pending and contemplated litigation, and real property.

Revised 2-25-81

Texas Department of Human Resources

John H. Reagan Building, Austin, Texas 78701

JEROME CHAPMAN
Commissioner

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February 26, 1981

TO: Chairman and Members
Texas Board of Human Resources

FROM: Marlin W. Johnston
Acting Commissioner

SUBJECT: Agenda Item No. 11 - Mid-Year Analysis of Nursing Home Reimbursement

The Board, at its July 16, 1980 meeting, approved new reimbursement rates for nursing homes to be effective for the period September 1, 1980 through August 31, 1981. There was concern expressed by industry representatives at the time that the percentage used to project minimum wage category salary expenses for nursing homes was too low. In response to this concern, the Board requested that Rate Setting staff conduct a mid-year analysis of nursing home reimbursement to ensure that rates were fair and reasonable.

The requested mid-year analysis is now complete. The findings of the analysis are shown below.

	Current Rates from June 1980 Analysis	Indicated Rates from February 1981 Analysis	Difference
SNF	$33.67	$33.64	$-0.03
ICF	26.06	26.04	-0.02
ICF II	22.90	22.91	+0.01

The indicated rates above were produced from a different set of data than the one used to determine current SNF/ICF reimbursement rates. The data for the mid-year analysis were much improved. Exhibit A, Page 2, details the differences in the data used for rate setting last summer and the data used for the mid-year analysis.

The inclusion of on-site audited cost report data in the mid-year analysis produced lower per diem expenses. This was the result of the removal of unallowable expenses which were reported on 1979 Cost Reports. The fiscal impact of on-site audited cost report data is exemplified in Exhibit B, Page 3.

The shift in relationships among level of care expenses was the result of the use of DHR paid days of service rather than the provider's reported days of service.

Industry representatives have again expressed concerns regarding DHR assumptions and estimates in last summer's analysis. Exhibit C, Pages 4 through 11, shows these concerns and the Department's responses.

It is respectfully requested that the Board act favorably on the recommendation shown below.

- Adopt the SNF per diem rate of $33.64, the ICF per diem rate of $26.04, and the ICF II per diem rate of $22.91, to be effective for the period March 1, 1981 through August 31, 1981.

The fiscal impact for State Fiscal Year 1981 of the rate change recommendation will be a decrease of $185,657 in expenditures.

Respectfully submitted,

Marlin W. Johnston
Acting Commissioner

Attachment

TEXAS DEPARTMENT OF HUMAN RESOURCES
OFFICE OF PROGRAMS BUDGET AND RATE SETTING
TEXAS MEDICAID SNF/ICF PROGRAM

Rate Setting Features for State Fiscal Year 1981 Reimbursement Rates for SNF/ICF Providers

	JULY 1980 ANALYSIS FOR RATES EFFECTIVE SEPTEMBER 1, 1980	JANUARY 1981 ANALYSIS AT MID-YEAR
• Data Base Composition		
. 1979 Cost Reports	839	876
. Desk-verified only cost reports	839	686
. Desk-verified and on-site audited cost reports	-0-	190
• Patient-Days of Service Used in Rate Setting	Reported Basis	DHR Paid Basis
• Inflation Assumptions (Estimated Annual Increases: SFY '81 over SFY '80)		
. Implicit Price Deflator - Personal Consumption Expenditures (Covers 32% of total expense. Used to project professional salaries; fringe benefits for all employees; and, miscellaneous expenses)	11.2%	11.2%
. Minimum Wage Index (Covers 37% of total expense. Used to project all nonprofessional salaries)	7.7%	7.8%
. Food Index (A composite index of the CPI-Food and Beverages and the PPI - Processed Foods and Feeds weighted 50/50. Covers 9% of total expense. Used to project raw food expense.)	11.6%	12.2%
. CPI - Property Tax	4.2%	4.2%
. CPI - Gas and Elecricity (Covers 3% of total expense)	9.1%	14.2%
. CPI - Property Insurance	10.1%	10.1%
. CPI - Automobile Insurance	8.1%	8.1%
. CPI - Telephone Service	3.9%	3.9%
. FICA, FUTA and Worker Compensation Insurance	Based upon statutory or regulatory increases	
• Administrative Caps on Certain Salaries		
. Maximum Allowable Per Diem Expense for Owner-Administrator	$1.759	$1.897
. Maximum Allowable Per Diem Expense for Owner-Assistant Administrator	$1.021	$1.083

Merle L. Moden
February 12, 1981

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TEXAS DEPARTMENT OF HUMAN RESOURCES

OFFICE OF PROGRAMS BUDGET AND RATE SETTING

TEXAS MEDICAID SNF/ICF PROGRAM

THE EFFECT OF ON-SITE AUDITED DATA UPON RATES
FOR THE PERIOD JANUARY 1, 1980 THROUGH AUGUST 31, 1980

*COMPOSITION OF 1978 COST REPORT DATA BASE

	Original Data Base		Altered Data Base	
	Number	%	Number	%
Desk Verified Cost Reports	790	100%	563	71%
Desk Verified and On-Site Audited Cost Reports	-0-	-0-	227	29%
TOTAL	790	100%	790	100%

*REIMBURSEMENT RATES

	From Original Data Base	From Altered Data Base	Changes	
			Amount	%
SNF	$31.95	$31.93	$-0.02	-0.01%
ICF	24.77	24.68	-0.09	-0.04
ICF II	21.76	21.66	-0.10	-0.05

*FISCAL IMPACT

	Days of Service 1/1/80 - 8/31/80	x	Rate Change	=	Over-Reimbursement
SNF	1,065,958	x	$0.02	=	$ 21,319
ICF	11,073,545	x	0.09	=	996,619
ICF II	3,538,703	x	0.10	=	353,870
TOTAL					$1,371,808

*PERCENT OF ERROR IN TOTAL VENDOR PAYMENTS

Over-Reimbursement	Total Vendor Payments	% of Error
$1,371,808	$292,425,140	0.5%

Merle L. Moden
February 12, 1981

EXHIBIT B

FEBRUARY 26, 1981 Board Agenda Item No. 11

TEXAS DEPARTMENT OF HUMAN RESOURCES
OFFICE OF PROGRAMS BUDGET AND RATE SETTING
TEXAS MEDICAID SNF/ICF PROGRAM

ISSUES IN THE MID-YEAR ANALYSIS OF SNF/ICF RATES
RAISED BY THE TEXAS NURSING HOME ASSOCIATION

TNHA POSITION	DHR POSITION
• The implicit price deflator is not an appropriate index to project costs for this industry; instead, the CPI should be used.	• The Implicit Price Deflator-Personal Consumption Expenditures (IPD-PCE) was adopted after extensive research and analysis conducted last summer. Rate Setting staff are convinced that this index is much more appropriate than the CPI-All Items. The shortcomings of the CPI-All Items are widely known and have been recognized by the Bureau of Labor Statistics which is the Federal agency maintaining the Consumer Price Indexes. The Implicit Price Deflator is based upon kinds and quantities of goods and services currently being purchased by consumers--not kinds and quantities of goods and services which were purchased in 1972-73 as is the case with the CPI-All Items.
• The minimum wage adjustment rate is too low. A rate of 7.7% was used to adjust minimum wage when experience shows it should have been 11%. This increase of 11% would have added an additional 25¢ to the September 1, 1980 rate (or 50¢ if paid from February 1, 1981).	• The 7.7% figure is the weighted average increase in the minimum wage rate from State Fiscal Year 1980 to State Fiscal Year 1981. This method of determining the percentage used to project minimum wage category salary expenses has served well in the past. However, it is argued that this is merely a self-fulfilling prophesy, since providers will only grant minimum increases. Nonetheless, most providers have been able to perform adequately under the increases granted in the past. The reimbursement methodology is based upon projections of historical expenses to determine rates. In cases where providers grant increases in excess of the projected increase, these expenses will be reported on subsequent cost reports and will be reflected in subsequent rates. The Department had concluded, however, that a survey of hourly wage rates from a random selection of providers would be useful in addressing this industry concern. Therefore, a 5% random sample of nursing home providers was surveyed in recent days. The weighted average percentage increase granted Merle L. Moden February 13, 1981

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EXHIBIT C
February 26, 1981 Board Agenda Item No. 11

TNHA POSITION	DHR POSITION
	minimum wage category employees was found to be 7.8 % Refer to Page 7 for details of the survey. Consequently, the percentage used in the mid-year analysis to project minimum wage category salary expenses will be 7.8%.
• Food costs have turned up rapidly and the current rate is estimated to be 10¢ to 20¢ low in this cost area.	• Food costs have increased in recent months and projections have taken these increases into account. Raw food costs are estimated to increase by 12.2%.
• There was no increase projected for many line items under facility costs. These costs have, in fact, escalated in nearly every case.	• The Department does not project increases in many facility expenses. Examples include depreciation, amortization, mortgage interest, and working capital interest.
• The profit expectation of 6% is unrealistic if assumed to be before tax profit.	• The average profit margin before income tax (from for-profit provider 1979 Cost Reports which were in the mid-year analysis) is 8.2%. Using an average income tax rate of 35%, the net profit margin is 5.4%. This net profit margin coupled with the after tax return on equity of 33.8% yields more than adequate profitability. Refer to Page 8. Comparison with other industries reflects favorable profitability of for-profit nursing homes. Refer to Page 9 for a comparative analysis.
• The industry must generate costs that are lower than the rate paid to stay in business. When rates are inadequate, the squeeze on costs will cause a deterioration in future services provided.	• Revenue short-falls appear to be caused mostly by declining caseloads. Refer to Page 10. Lower occupancy provides higher expenses per day of service. Options available to a provider experiencing revenue decline include reducing services, eliminating unnecessary expenses, and reducing profit margins. In the open market, a provider reducing services would soon go out of business. Reducing services will not only jeopardize compliance with standards, but will reduce the attractiveness of a particular facility to private as well as Medicaid patients. Unnecessary expenses

Merle L. Moden
February 13, 1981

TNHA POSITION	DHR POSITION
	for non-essential items can be eliminated without an adverse effect on the quality of care. Profit margins can be reduced in the short run while the provider's investment becomes more viable through improved occupancy and/or improved cost efficiency. Government providers should not be inflation-proofed. The effect of inflation upon providers, their stockholders, and their employees should be no different from that experienced by the average citizen. Increases in real income have declined in recent months as shown on Page 11. There is little reason to believe, given continued inflationary pressure, that this trend will reverse itself for many months to come. For example, per capita disposable personal income declined for five consecutive quarters during the 1974 recession. Providers should not look to the Department to protect them from the inflation experienced by society as a whole. There is a point where rate increases do not simply respond to inflation, but actually become forces which drive inflation.

Merle L. Moden
February 13, 1981

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TEXAS DEPARTMENT OF HUMAN RESOURCES
OFFICE OF PROGRAMS BUDGET AND RATE SETTING
TEXAS MEDICAID SNF/ICF PROGRAM

RESULTS OF THE HOURLY WAGE RATE SURVEY FOR
LONG TERM CARE FACILITY NON-PROFESSIONAL EMPLOYEES
EARNING LESS THAN $4.50 PER HOUR

* GENERAL INFORMATION

Method of Selecting Facilities.....5% Random Sample
Number of Facilities Surveyed.....53
Number of Employees Surveyed.....784
Survey Period.....September 1979 through January 1981
Survey Technique.....Hourly Wage Rates at the end of each month in the survey period were recorded for up to 15 employees in each facility.

* HOURLY WAGE RATE AVERAGES

Average Hourly Wage Rate in Base Period (SFY 1980)[1].....3.160
Average Hourly Wage Rate in Projected Period (SFY 1981)[2].....3.408

* AVERAGE PERCENTAGE INCREASE

Sum of Hourly Wage Rates in Base Period (SFY 1980).....2,477.68
Sum of Hourly Wage Rates in Projected Period (SFY 1981).....2,671.93
Average Percentage Increase.....7.84%

[1]Many hourly wage rates were inserted at the minimum wage level since high turnover rates result in a substantial number of employees with less than a year on staff.

[2]Hourly wage rates were projected at the same level for the 8 month period January 1980 through August 1981. Due to the significant turnover in these personnel, it is inappropriate to attempt to project increases.

Merle L. Moden
February 25, 1981

EXHIBIT C
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TEXAS DEPARTMENT OF HUMAN RESOURCES
OFFICE OF PROGRAMS BUDGET AND RATE SETTING
TEXAS MEDICAID SNF/ICF PROGRAM

* 1979 SNF/ICF AVERAGES *

INCOME STATEMENT	ALL PROVIDERS (876)	FOR-PROFIT PROVIDERS		
		ALL (758)	OWNING ITS FACILITY (405)	LEASING ITS FACILITY (353)
REVENUES				
PATIENT GROSS REVENUE	$702,010	$692,942	$684,868	$702,205
OTHER GROSS REVENUE	11,164	5,904	5,904	6,079
TOTAL GROSS REVENUE	713,174	698,927	690,772	708,284
LESS: ALLOWANCES	(4,258)	(3,469)	(2,485)	(4,598)
TOTAL NET REVENUE	708,916	695,458	688,287	703,686
EXPENSES				
PATIENT CARE COST AREA	$328,135	$311,688	$317,360	$305,180
DIETARY CARE COST AREA	118,243	112,409	114,362	110,170
FACILITY COST AREA	140,298	138,308	126,150	152,257
ADMINISTRATION COST AREA	76,234	75,799	74,968	76,752
TOTAL NET EXPENSE	662,910	638,204	632,840	644,359
PROFIT	46,006	57,254	55,447	59,327
PROFIT MARGIN				
BEFORE INCOME TAX	6.5%	8.2%	8.1%	8.4%
AFTER INCOME TAX (ASSUME 35% TAX RATE)	NA	5.4%	5.2%	5.5%
BALANCE SHEET				
TOTAL ASSETS	$495,400	$417,005	$592,419	$215,859
TOTAL LIABILITIES	332,356	292,872	441,456	122,401
TOTAL CAPITAL	163,044	124,183	150,963	93,458
TOTAL LIABILITIES AND CAPITAL	495,400	417,005	592,419	215,859
ALLOWABLE EQUITY	NA	110,179	137,925	78,347
RETURN ON EQUITY				
BEFORE INCOME TAX	NA	52.0%	40.2%	75.7%
AFTER INCOME TAX (ASSUME 35% TAX RATE)	NA	33.8%	26.1%	49.2%

Merle L. Moden
February 12, 1981

TEXAS DEPARTMENT OF HUMAN RESOURCES
OFFICE OF PROGRAMS BUDGET AND RATE SETTING
TEXAS MEDICAID SNF/ICF PROGRAM

COMPARATIVE 1979 FINANCIAL PERFORMANCE:
THE AVERAGE FOR-PROFIT TEXAS MEDICAID SNF/ICF
VERSUS
169 TOP PERFORMERS IN 6 INDUSTRIES

	INDUSTRY[1]						
	RETAIL STORE[3]	PETROLEUM (INTEGRATED)[4]	NATURAL GAS[5]	TEXAS NURSING HOMES[6]	TEXAS BANKING[7]	MEDICAL SERVICES[8]	FAST FOOD[9]
Net Profit Margin[2]	3.2%	7.5%	5.6%	5.4%	NA	5.7%	4.4%
Return on Equity[2]	12.2%	22.9%	14.7%	33.8%	15.3%	16.7%	14.4%

[1] All statistics except for Texas Medicaid SNFs/ICFs are from 1980 and 1981 issues of the Value Line survey of top performing companies.

[2] After income tax.

[3] Thirty-nine entities including Allied Stores, Federated Department Stores, K Mart Corp., G. C. Murphy Co., J. C. Penney Co., Pier 1 Imports, and Sears, Roebuck and Co.

[4] Forty-five entities including Atlantic Richfield, Conoco, Exxon, Gulf, Mobil, Phillips Petroleum, Shell, Standard Oil (California), Standard Oil (Indiana), Standard Oil (Ohio), and Texaco.

[5] Fifty-three entities including El Paso Company, ENSEARCH Corp., Houston Natural Gas, Tenneco Inc., Texas Eastern Corp., Texas Gas Transmission, and Valero Energy Corp.

[6] 758 Texas Medicaid SNF/ICF For-Profit providers. The income tax rate assumption is 35%.

[7] Four entities including Mercantile Texas Corp. (9 banks), Republic of Texas Corp. (26 banks), Southwest Bancshares (20 banks), and Texas Commerce Bancshares (39 banks).

[8] Eleven entities including Beverly Enterprises with 314 nursing homes (70 in Texas), Cenco, Inc., with 55 nursing homes, and National Medical Enterprises with 114 nursing homes.

[9] Seventeen entities including Church's Fried Chicken, Inc., Denny's, Inc., Dunkin' Donuts, Inc., McDonald's Corp., Pizza Inn, Sambo's Restaurants, Victoria Station, Inc., and Wendy's International, Inc.

Merle L. Moden
February 12, 1981

EXHIBIT C
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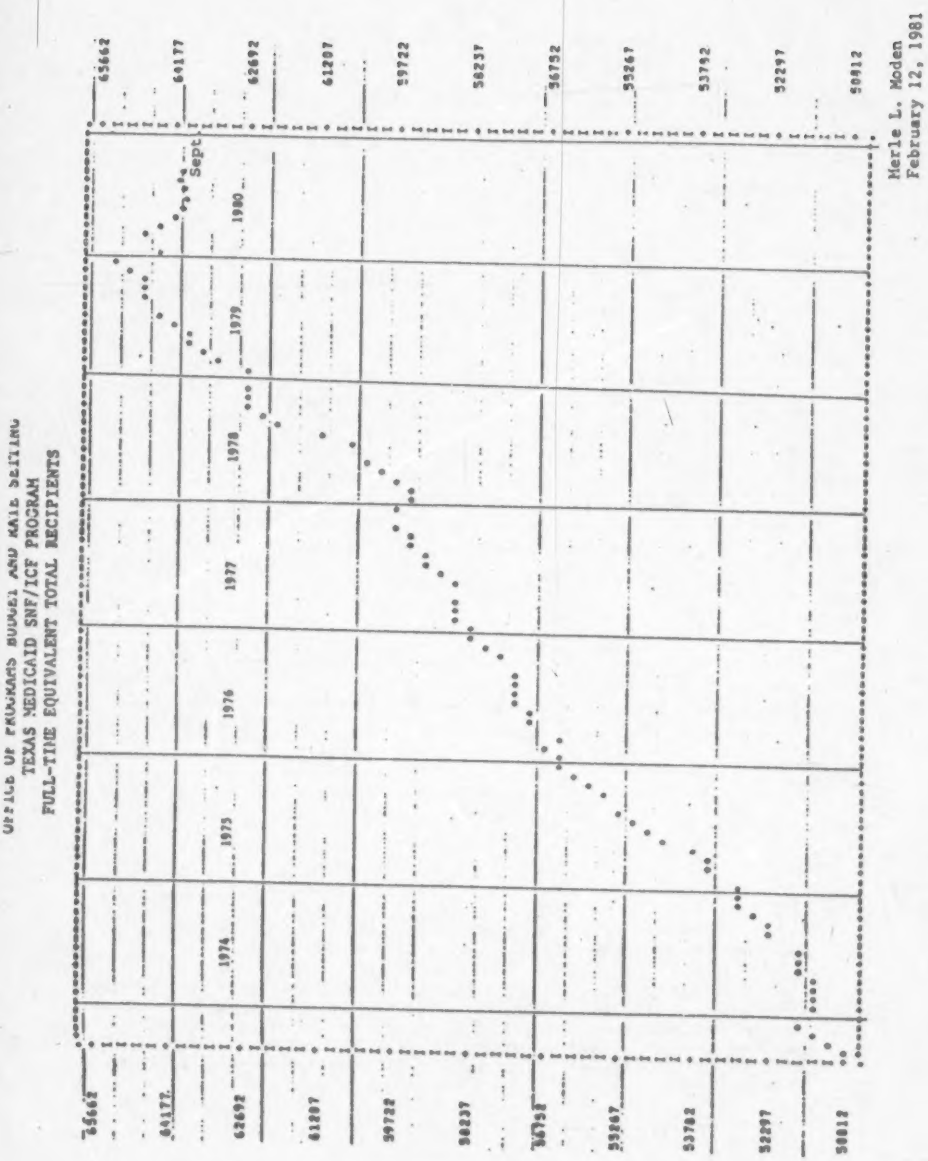

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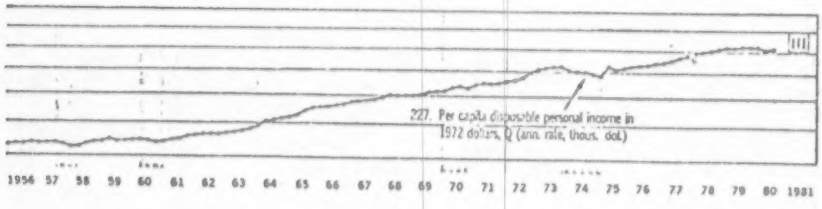
TEXAS DEPARTMENT OF HUMAN RESOURCES
OFFICE OF PROGRAMS BUDGET AND RATE SETTING
TEXAS MEDICAID SNF/ICF PROGRAM

RECENT TRENDS[1] IN U.S. PER CAPITA
DISPOSABLE PERSONAL INCOME IN 1972 DOLLARS[2]

		ANNUAL RATE OF CHANGE[3]
1978		
1st Quarter	$4,434	+5.6%
2nd Quarter	$4,465	+4.9%
3rd Quarter	$4,502	+4.4%
4th Quarter	$4,547	+3.9%
1979		
1st Quarter	$4,574	+3.2%
2nd Quarter	$4,570	+2.4%
3rd Quarter	$4,598	+2.1%
4th Quarter	$4,596	+1.1%
1980		
1st Quarter	$4,596	+0.6%
2nd Quarter	$4,528	-0.9%
3rd Quarter	$4,561	-0.8%



[1]December 1980 issue of Business Conditions Digest, a publication of the Bureau of Economic Analysis, U.S. Department of Commerce.

[2]Disposable income is the personal income available for spending or saving. It consists of personal income less personal taxes and nontax payments to government. Measurement in 1972 dollars reflects the real purchasing power of disposable personal income in recent years compared to 1972. The deflator for this series is the Implicit Price Deflator--Personal Consumption Expenditures.

[3]Measured quarter to quarter.

Merle L. Noden
February 16, 1981

EXHIBIT C
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DHR Regions

Appendix II

★ Regional Offices
☆ Sub-Regional Offices
• Major Administrative Offices

Texas Dept. of Human Resources
AMII 79 5/March 1979

D ····· Monday, April 27, 1981, DALLAS TIMES HERALD

Texas nursing homes turn average 33.8 per cent profit

By SARALEE TIEDE
Austin Bureau

AUSTIN — Texas nursing homes returned more profit to their owners in 1979 than petroleum companies, banks, fast food franchises or retail stores, according to an analysis prepared by the Department of Human Resources.

A compilation of cost statements from 839 nursing homes filed with the department showed that homes returned 33.8 per cent on equity after taxes, compared to 22.9 per cent for oil companies, 15.3 per cent for Texas banks, 14.7 per cent for natural gas companies, 14.4 per cent for fast food businesses and 12.2 per cent for retail stores.

However, some nursing home operators contend that the state's profit calculations are grossly unfair to those who try to run well-staffed, comfortable homes.

Dell Hagen, president of the National College of Nursing Administrators and part owner of the Hearthstone Nursing Home in Tyler, said the profit figure is enlarged by poorly-run homes that cut corners on staff and food to save money.

The profit analysis was made after the industry protested that their reimbursement for Medicaid patients was too low, but the findings prompted the board to cut rates further, by three cents a day for skilled nursing facilities and two cents a day for intermediate care homes.

Nursing homes now receive $33.64 a day under Medicaid for skilled care and $26.04 daily for intermediate care. The Texas Nursing Home Association is lobbying vigorously this legislative session to raise that rate.

At least two legislative committees have recommended that the state adopt tighter restrictions on nursing home payments which have encouraged expansion of the industry in Texas, led to overbuilding and, in turn, to even more expensive care because of the cost of keeping unused beds.

The Special Committee on the Delivery of Human Services pointed out last year that Texas spends more than half a billion each year on nursing home care.

"The number of nursing home beds in Texas increased [illegible] per cent from 1960 to 1978, two... the increase nationwide," the report said. "Texas currently has 104,000 nursing home beds of which 18,000 are empty."

The committee recommended that the Department of Human Resources, which administers Medicaid money, impose limits on certain costs, audit homes that show unusually high operating expenses and fine those that fail to submit an annual operational cost report.

"A study of the nursing home industry in Texas indicated that incentives are needed for maximizing the use of taxpayer dollars while meeting one of the most important public needs of contemporary society," the report said, noting that the entire industry suffers from "cost-push" problems.

A 1976 study, done by the Joint Advisory Committee on Government Operations suggested a new emphasis on alternative programs that would permit the elderly to remain in their own homes.

Adequate alternative care programs could delay the entry of many aged people into nursing homes and could be operated far more cheaply than the nursing home program, the report said.

ITEM 8

JUN 14 1981

AUSTIN-AMERICAN STATESMAN

Do nursing homes make enough money?

By ABBY KAIGHIN
American-Statesman Staff

Austin nursing-home owner Tom Taylor sings the blues when the subject of money comes up.

"It's hard to operate and stay in business when we're paid $26.01 per day per patient," he said.

"The problem is, the state wants us to give total care, but it isn't willing to pay for it. For $26.04 a day (per patient under Medicaid) we are required to furnish medical, emotional and spiritual needs. You can't check into a hotel for anywhere near that kind of price."

Taylor is a past leader in the Texas Nursing Home Association and its national counterpart. His comments are typical of leaders in the nursing-home industry. The state's rates, they say, are inadequate to cover their costs and that causes a deterioration in the quality of service.

Merle Moden, a state Department of Human Resources official who oversees the setting of nursing-home payment rates, is familiar with the owners' sad song. But, he said, it strikes a few discordant notes, coming from an industry whose financial return on investment, percentage-wise, greatly exceeds the petroleum industry's.

Moden said Texas' nursing-home industry generally makes money — lots of it. The problem, he said, is that studies show no correlation between money spent for nursing-home care and the quality of care that is rendered.

"The nursing-home industry in Texas is fat," Moden said, pulling out thick stacks of computer printouts, statistical studies and data to back his contention.

And Taylor's 150-bed Austin Nursing & Convalescent Center, 110 E. Live Oak St., is doing far better than the average Texas nursing home, Moden said. Although Taylor said he made only a 1.1 percent profit in 1979, cost reports he filed with the state showed he made a 7.8 percent pretax profit.

Moden also noted that the home's $104,112 profit for 1979 (the latest year available) doesn't reflect the total amount of money Taylor made from his business. In addition to the profit, Taylor paid his wife $82,114 as the nursing home's administrator and himself $24,534 as assistant administrator.

Taylor said his actual profit was $23,000, not $104,000, because the department doesn't allow certain expenses to be calculated in its analysis of homes' income statements. He was unable, however, to pinpoint expenses that accounted for the entire $81,000 difference between his profit figure and the department's. One item he identified was more than $16,000 for owners' life insurance, an expense considered "unallowable" by the department.

The Texas nursing-home industry, according to Department of Human Resources analyses, is much more lucrative than the petroleum industry in terms of return on the money invested. In 1979, Texas nursing homes — as a group — realized a 33.8 percent return on equity. That compares with the petroleum industry's 22.9 percent.

Nursing-home-industry leaders — Taylor included — quarrel with return on money invested as a measure of success. They say that because the nursing-home industry is "highly leveraged" — meaning a person may put up a small amount of money and borrow the rest — the return on equity is an inappropriate yardstick to use.

Moden said the department used "generally accepted accounting principles" to figure the rate of return on equity and they apply to all industries.

Texas nursing homes, in 1979, had an average profit margin of 5.4 percent after taxes. That's the money they made after expenses were subtracted from revenues and after taxes were paid on the net revenue.

Moden contrasts that with the profit margins of other industries as reported in *Value Line*, a financial-analysis publication. The analysis shows that the 186 top performers in retail stores nationwide had a 3.2 percent profit margin after taxes; fast-food outlets,

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4.4 percent; and the natural-gas industry, 5.6 percent.

Industry leaders claim the state doesn't allow all their costs to be included in the cost reports on which the state payment rates are based. Moden said that is true. For example, he noted, luxury vehicles are not allowed to be included as transportation costs. Therefore, the state rejected Austin Nursing & Convalescent Center owner Tom Taylor's effort to include three Mercedes (one was traded in for another midyear), CD radios and a speed-radar detector on his cost report.

Moden said unallowable costs are ones that don't directly affect patient care. He noted that while the state will not reimburse homes for some costs, those costs are usually deductible on the homes' tax returns.

Taylor said nursing-home operators' costs are reduced by the state in several ways, including limits on the salaries of owner-administrators.

Moden said that is done because owner-administrators' services are not "sold" in the marketplace.

The department puts the maximum salary for an owner-administrator at 90 percent of the highest-paid hired administrator in the state.

"Having a limit that high," Moden said, "doesn't deal with the issue that the highest-paid employed administrator might be running a 300-bed facility while an owner-administrator of a 60-bed facility could be paying himself the same salary."

The state is planning to devise a more equitable schedule on which to limit owner-administrators' salaries, he said.

Taylor defends his wife's $82,114 salary — which exceeds the salaries of Austin's hospital administrators — by noting that she has 24-hour responsibility for the home. And, he said, he and his wife have "ownership" responsibilities, unlike the hospital administrators.

There is one thing Moden and Taylor agree on and that is that money alone cannot ensure quality care.

Moden said that a couple years ago, when industry leaders kept repeating their claim that "you can't get first-class care with third-class payments," the department conducted some studies.

"You would assume, that if money determines the quality of care, then you'd expect the homes with the most verified complaints or citations (by the health department) would have the lowest costs," Moden said.

Using that assumption as the basis for the study, the welfare department culled out from health-department records the homes with the most violations.

"The theory would be that at maximum costs there would be no complaints and at the other end — the providers who spend the least money — there would be the maximum number of complaints," Moden said.

But statistically it didn't turn out that way. The study showed no relationship between costs and quality.

The department d'd another study, assuming that homes with the lowest food costs "would be starving their patients . . . . We printed out (by computer) the homes in the bottom 10 percent of food costs. Then, our investigators did on-site reviews of menus and diets.

"The bottom line was there was no reason to conclude the food wasn't adequate. How above adequate it was was a question of taste, but some of the homes that spent the least to purchase and prepare food had good food," Moden said.

But Taylor, whose center is considered by state officials to be one of the better Austin nursing homes, said the profit isn't adequate.

"A reasonable profit to a businessman isn't a dirty word," he said. "In my judgment, the normal return to any business should be 10 to 12 percent. I've never approached that and I don't expect I ever will."

Moden said he thought that kind of profit expectation was unrealistic in light of the fact that most industries aren't making that kind of return.

He said that when the nonprofit homes are excluded from the calculations, nearly 90 percent of the state's nursing homes are making a profit. Some may not be making much of a profit, but then, he said, it's not the state's role to guarantee that every nursing home owner makes a profit.

"When you talk about new businesses — you don't normally expect to make a profit immediately. I think this industry is extremely healthy and this is with an 82 percent occupancy level. If they can do that with that kind of occupancy level, we're paying too much."

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